AN EXPLORATION OF WOMEN'S EXPERIENCES OF EMOTIONAL AMBIVALENCE DURING THEIR FIRST TRIMESTER OF PREGNANCY AND THEIR PERCEPTIONS OF PSYCHOSOCIAL SUPPORT DURING THAT TIME

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Abstract

The first trimester is a vital stage of pregnancy. Many important developmental changes take place for both mother and baby during this time. These changes are vast and fast paced and encompass changes to a woman's body, their emotional and also their social wellbeing. This qualitative study aimed to gain insight into women's experiences of emotional ambivalence and their perception of psychosocial support during the stage of the first trimester of pregnancy. Through Interpretative Phenomenological Analysis (IPA), super-ordinate themes and sub-ordinate themes were identified. Hearing first-hand accounts of four women's lived experiences highlighted the prevalence of emotional ambivalence during the first trimester. It also exposed the reality and impact of perceived support that was deemed beneficial including support from significant relationships and support that was considered lacking including emotional holding and individually-led support. This study has added to the conversation that there is scope for further research with the view to addressing women's mental and emotional wellbeing and the standard of perceived support they receive during the first trimester of pregnancy.

Declaration

The material being presented for examination is my own work and has not been submitted for an award of this or another HEI except in minor particulars which are explicitly noted in the body of the dissertation. Where research pertaining to the dissertation was undertaken collaboratively, the nature and extent of my contribution has been made explicit.

I confirm that this dissertation is entirely my own work

Signed: *L LEMANSKI*

Dated: 03/10/19

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Finally, I dedicate this dissertation to my Jacob and Zoe.

You both show me daily what it feels like to love and be loved.

Thank you

Contents

Chapter 1 – Introduction

Research Question

How do women experience emotional ambivalence during their first trimester of pregnancy and what are their perceptions of psychosocial support during that time?

Aims

- To examine women's emotional experiences of ambivalence during their first trimester of pregnancy.
- To explore women's perceptions of psychosocial support during the time of their first trimester of pregnancy.

Within this small-scale research project, I aim to explore women's emotional experiences during their first trimester of pregnancy. This research study intends to explore experiences of emotional ambivalence a woman may have encountered during her first trimester of pregnancy. It also intends to explore the perceptions of psychosocial support and examine the necessity or potential value support can have during this time. This research study endeavours to present experiences of emotional ambivalence and psychosocial support from a qualitative and inductive research paradigm. This study intends to potentially raise awareness of women's experiences during the first trimester of pregnancy to other women, social support networks, healthcare professionals and the counselling sector.

Positioning Statement

The rationale of this study derived from my own experiences of pregnancy. My initial pregnancy experience started with pregnancy loss when I miscarried my first baby. Two successive pregnancies after my pregnancy loss resulted in two beautiful children. Reflecting back on my emotional experience during my three encounters of the first trimester of

pregnancy, it filled me with a maelstrom of feelings including delight, worry, fear, elation, concern and excitement. The emotional pull between the elation about becoming pregnant, becoming a mum, starting a family and the trepidation of something 'going wrong' left me feeling guilty and also isolated as I felt that I couldn't verbally communicate my ambivalence in case I 'jinxed' the pregnancy. Although my husband and some close family members and friends were fully supportive, I found myself feeling isolated as I was the one who was experiencing the vast physical and emotional changes and felt that they couldn't fully understand my experience. My experience of healthcare during the first trimester consisted of advice on how to maintain a healthy pregnancy. I do not recall being asked about my emotional wellbeing.

Context

Mullin (2005) describes the changes a woman undertakes during pregnancy including changes to their body, their emotional and their social wellbeing as dramatic and fast paced. Existing research identifies a need to look into early pregnancy wellbeing. Cutler, McNamara, Qasba, Kennedy, Lundsberg and Gariepy's (2017, p.75) study titled "I just don't know" examined how ambivalence manifests itself in women's experiences after confirmation of pregnancy and found that over half their sample described feelings of ambivalence regarding their current pregnancy. Bauer, Parsonage, Knapp, Lemmi and Adelaja (2014) publicised that between 10 and 20% of women develop a mental health illness during pregnancy or within the first year after having a baby**,** and in almost half of the UK pregnant women and new mothers don't have access to perinatal mental health services, possibly leaving them and their babies at risk. Bauer et al. (2014) state that research shows that only 3% of Clinical Commissioning Groups (CCG's) in England have a strategy for perinatal mental health services and a large majority have no plans to develop one. NICE guidelines (2019, p.4) for antenatal care for uncomplicated pregnancies does not screen nor mention any emotional or psychological factors during the 'first contact with a healthcare professional' or 'at booking

(ideally by 10 weeks)'. Cutler et al. (2017) concluded that exploring and acknowledging sources of ambivalence regarding pregnancy may help health providers and policymakers to comprehensively support women during this time. A new campaign initiated by NSPCC (2019) titled "Fight for a fair start" is currently demanding perinatal mental health support for every Mum, so that every baby and every family get a fair start.

Weis' (2006) study researching the relationship of community support and family adaptability to prenatal maternal adaptation reflected the importance of some form of perceived network of support as early as the first trimester (Lederman & Weis, 2009). I am aware that my experience of emotional ambivalence was influenced by my previous experiences and social circumstances, however, I am driven both personally and professionally within a Person-Centred counselling context, to find out if emotional ambivalence is prevalent during the first trimester of pregnancy regardless of a women's previous experiences and social circumstances. I am also keen to explore women's perceptions of psychosocial support to examine the contribution it made to their first trimester experience.

Dissertation Overview

This chapter has set out the question, aims, positioning statement and context of the study. Chapter 2, the literature review**,** briefly outlines assumptions of pregnancy being a phenomenological experience and explores research and literature relevant to emotional difficulties and emotional ambivalence during pregnancy noting early pregnancy specifically. It will also explore literature and research relevant to pregnancy and psychosocial support, its underpinning principles, support networks and its benefits and shortfalls. Chapter 3 will discuss the research paradigm and explain the choice of methodology for the study, interpretive phenomenological analysis (IPA). It will also discuss participant recruitment, the selection process, the data collection process and the data analysis process. Additionally, this chapter will explain how ethical issues were considered, and how validity and

trustworthiness of the study was ensured. Chapter 4, findings, aims to provide a thematic description of the participants lived experiences of emotional ambivalence and perceptions of psychosocial support correlating with the study's research aims. The study's discussion, chapter 5, aims to draw together the outcomes delivered from the analysis in chapter 4 and the previous and relevant literature reviewed in chapter 2. Finally, Chapter 6, will conclude by summarising my research and discuss implications, limitations and further research potential.

Chapter 2: Literature Review

> "The search and review of literature is a critical evaluation, analysis and synthesis of existing knowledge relevant to your own research problem. It is a synthesis in that you are required to show the relationships that exist between different studies and show how these relate to your own research."
>
> (Hart, 2005, p.153)

Literature Review Process

Carrying out a literature review has enabled me to explore the field in which I intend to study. In order to acquire an understanding of existing literature, I formulated a research strategy (appendix 1) and began my initial search using the University of Chester's main library catalogue, PsycINFO, online journal portal as well as Google and Wikipedia.

Searching for keywords and phrases from my research question and aims, in particular 'first trimester of pregnancy' and 'emotional ambivalence' did not provide me with a substantive amount of literature or current research. I dissected key phrases and used Booleans and truncations such as (preg* AND ambivalence) and (emotional amb* AND antenatal) which led me to locating some studies although trying to locate recent research surrounding women's experiences of *emotional* ambivalence proved difficult. During the literature search, many avenues of ambivalent experiences presented themselves including maternal ambivalence, pregnancy ambivalence, goal ambivalence, specific emotional difficulties including anxiety and depression, but emotional ambivalence did not present itself separately. The literature mostly pinned emotional experiences onto subject content including pregnancy loss, wanted pregnancy and abortion, conception difficulties and birth and maternal anxieties. I endeavoured to avoid including subject based pregnancy experiences as a part of this literature review as I wanted to explore the nature of emotional ambivalence as broadly as possible. I found even less literature surrounding the first trimester experience. However,

searches seeking literature on psychosocial support OR support AND pregnancy yielded more results with relevant findings to my research question and aim. I have been mindful to avoid literature involving how social support during pregnancy is measured due to quantitative restricting factors. I have directed my literature research to exploring groups of psychosocial support and its perceived use during a women's pregnancy experience.

The study that emerged in a keyword/phrase search (appendix 2) lead me to look further into key studies that highlighted what was missing. Therefore, I have embarked on a thematic review of relevant literature and research that orbits my research question and aims and that was deemed pertinent rather than solely looking for research directly related to the themes of emotional ambivalence and psychosocial support.

This chapter will outline assumptions of pregnancy and phenomenology and will briefly outline definitions of ambivalence and emotional ambivalence. It will also explore studies and literature that identify looking at emotional difficulties and emotional ambivalence during pregnancy and then highlight what may be getting overlooked within the earlier stages of pregnancy with specific reference to the first trimester. Furthermore, this chapter will explore literature and research relevant to pregnancy and psychosocial support, its underpinning principles, support networks and its benefits and shortfalls.

Pregnancy and Phenomenology

Leff (2005) suggests that each expectant parent responds differently to the mass of arousing and frequently contradictory physical and emotional experiences that pregnancy sets in motion. The experience of pregnancy which has been noticed as a stressful life event was placed 12th in its category of 43 life events with a mean value of 40 on the Holmes-Rahe (1969) life stress inventory derived from the social readjustment rating scale (SRRS) (Mearns, 2010). Mullin highlights work from feminist philosophers Levesque-Lopman (1983), Young (1984) and Bigwood (1991) drawing attention to the enormity of the phenomena of pregnancy as

"blurred boundaries between self and other, the enormous amount of change pregnant women experience, and the challenges to women's self-understanding that result from both" (Mullin, 2005, p.91). With regards to underpinning philosophy of phenomenology in relation to person-centred theory, Rogers (1951) highlights "an important truth in regard to this private world of the individual is that it can only be known, in any genuine or complete sense, to the individual himself… no matter how much we attempt to measure the perceived organism… it is still true that the individual is the only one who can know how the experience was perceived" (Rogers, 1951, p.483). Merry (2002, p.18) also states that "the way we experience the world, and therefore the way we respond to it, results from the sense and meaning we each derive from our own unique mixture of needs, history and expectations. Each of us, then, lives in our own subjective world, which cannot be fully and completely understood by anyone else". Drawing on the notions of phenomenology, Levesque-Lopman cited in Mullin (2005, p.45) denotes the process of pregnancy will involve "a reconstruction of the way I interpret my own experience of pregnancy and childbirth" (1983, 251) and argues to uphold the respect of each women's individual experience stating "the fact that it is now being reflected upon by one woman" does not "discount its meaningfulness for other women" (1982, 252). Hunter (1994) also maintains that experiences of reproductive changes and problems for women differ considerably. Weinstein (2016) conveys the importance of identifying pregnancy as phenomenology of the body and denotes any interaction with a pregnant mother should warrant honoring her unique body-based experience without placing assumptions on many people having the same experience.

Ambivalence and Emotional Ambivalence

Merriam-Webster's (2019) defines the term, ambivalence as "simultaneous and contradictory attitudes or feelings (such as attraction and repulsion) toward an object, person, or action' and as a 'continual fluctuation (as between one thing and its opposite". Friedman (2014) extends the definition to infiltrate emotional experiencing with ambivalence defining emotional

ambivalence as a “particularly complex emotion characterised by tension and conflict that is felt when someone experiences both positive and negative emotions simultaneously”. The concept of emotional ambivalence can also be referred to as ‘subjective ambivalence or felt ambivalence’ that represents perceptions of mixed feelings, mixed reactions, the psychological experience of conflict or indecision (Conner & Armitage, 2008). Schneider (2013, p.18) suggests that ambivalence may also manifest itself from body movements evidenced from language used including, “torn or wavering between two sides” and “on the one hand… but on the other hand”.

Emotional Ambivalence and Experiencing During Pregnancy

Mullin (2005) describes the changes a woman undertakes during pregnancy including changes to their body, their emotional and their social wellbeing as dramatic and fast paced. Page (1988) in Ball (1994) quite poignantly offers an account of pregnancy**,** reflecting on the mixture of feelings felt including ambivalence, the ‘wretchedness of morning sickness’, joy, anxiety, disappointment and family disruptions of pregnancy. Page describes pregnancy not only as a physical event, but also a sexual and spiritual event, “full of a range of emotions**:** happiness and joy, fear, anxiety, anger and frustration, grief and poignancy… joy and ecstasy and infinite tenderness” (Page, 1988 in Ball, 1994, p.15). Ledermand and Weis, (2009, p.50) maintain that some degree of ambivalence may be experienced “even for women who plan, accept, and enjoy pregnancy” and is considered normal at first. Women’s experiences of ambivalence towards their pregnancy are however “not necessarily considered normal throughout pregnancy” and may be deemed symptomatic of unresolved conflict if they remain prevalent during the third trimester. A lot of literature and research somewhat targets the more adverse experience towards emotions. I therefore thought it would be valuable to refer to Brown (1998) in Ledermand and Weis (2009, p.53) who found that “pregnancy included simultaneous positive and negative experiences, but that feelings of well-being prevailed”. Ledermand and Weis (2009, p.53) also raise the point that, “others found that women who

were happier about the pregnancy used a greater range of cognitive and behavioural coping strategies to deal with negative moods or affect (Blake et al., 2007; Facchinetti, Ottolini, Fazzio, Rigatelli & Volpe, 2007).

I have found that there is sparse literature and relevant research that focusses on feelings of emotional ambivalence during pregnancy. Mullin (2005, p.73) states that, "the ambivalent nature of many women's responses to pregnancy is ignored." Sherr suggested women experience being "questioned in detail about their clinical experiences, yet very little is known of their day-to-day feelings and changes during pregnancy" (Sherr, 1995, p.115). Geller (2014) highlights the assumption that pregnancy is typically associated with positive emotions, and notes that the reality of this is not the case for all women or pregnancies. Sherr (1995) argues that very little research surrounding pregnancy is psychologically based and is either medically, economically or socially based. Research is often biased and presumptions towards pregnancy being deemed as enjoyable, desirable and a 'natural state' for women regardless of a growing critical view of this opinion (Usher, 1989 cited in Sherr, 1995).

Miller, Barber and Gatney (2013) argue that although investigations of pregnancy have gained significant traction, assessment surrounding ambivalence toward pregnancy is often ambiguous and not necessarily backed by a sound theoretical underpinning. Koletzko, La Marca-Ghaemmaghami and Brandstatter (2015, p.266) highlight that investigations of pregnancy ambivalence have largely been concerned with ambivalence "toward a potential pregnancy in non-pregnant, often adolescent, populations with no explicit pregnancy intentions, focusing on outcomes such as contraceptive behavior or unplanned pregnancies" (e.g. Brückner, Martin, & Bearman, 2004; Miller, Barber, & Gatny, 2013; Schwarz, Lohr, Gold, & Gerbert, 2007)". Even though Koletzko et al.'s (2015) study focuses on assessing the effects of goal ambivalence on wellbeing, stress and coping among women during pregnancy differs from my exploratory intentions of looking at emotional ambivalence and psychosocial support, it highlights a missing field of examining wanted pregnancy and /or planned pregnancies. My

intention is to explore the experiences of emotional ambivalence during the first trimester of pregnancy regardless of whether the pregnancy was intentional.

Qiao, Wang and Ablat's (2009) study on risk factors of anxiety and depression symptoms among Chinese pregnant women notes that emotional problems during pregnancy are deemed very harmful to the mother, as well as the foetus/new-born's health. Adverse events can derive from depression and other stressful feelings during the prenatal period. These harmful effects have been widely reported. Gourounti, Anagnostopolous and Lykeridou (2013) argue further that research and intervention programs maintain their focus on postnatal depression and largely underestimate the importance that antenatal anxiety and depression has during pregnancy. Their research aimed to examine coping strategies, alongside antenatal anxiety, pregnancy worries and depressive symptomatology, with the intention to assist in identifying women who may be at risk of experiencing high stress and in need of support by exploring women's experiences of coping with their emotional pregnancy difficulties during a gestational range of 11 to 26 weeks. Their study identified risk factors that had the potential to be looked at further to decrease the psychological burden for women during pregnancy.

The studies mentioned have all taken pregnancy experiences into consideration during the second trimester of pregnancy. Rubertsson, Hellstrom, Cross and Sydsjo's (2014) study extended from the findings of Andersson et al. (2003a) and Kringeland et al. (2009) who largely focused on the occurrence of anxiety during pregnancy. Rubertsson et al. (2014) indicated that anxiety was more prevalent than depression during early pregnancy and the consequences of experiencing anxiety during pregnancy for both mother and baby should indeed be investigated to examine the factors that contribute to the presence of anxiety during the first trimester of pregnancy. Maconochie, Doyle, Prior and Simmons (2007) found that risk factors for first trimester miscarriage related to emotional wellbeing in pregnancy. They state that, "stress and traumatic events appear to increase risk; feeling relaxed and happy appears

to decrease the risk" (Maconochie et al., 2007, p.183). All of the studies mentioned reached their findings using quantitative research methods.

Psychosocial Support Principles

> "When a woman was having a baby, nobody seemed to be interested in her until she was seven months pregnant. Nobody thought about antenatal care then. There were no antenatal beds. (Reflections of Eileen O'Brien read at a service for the Royal College of Midwives to celebrate 100 years of professional midwifery, May 31st 2002)".
>
> (Stewart, 2004, p.46)

Wheatley (1998) finds Schumaker and Brownell's (1984) definition of psychosocial support: "an exchange of resources between at least two individuals perceived by the provider of the recipient to be intended to enhance the wellbeing of the recipient" as an appropriate definition when discussing psychosocial support in pregnancy. Wheatley (1998) talked about the current school of thought proposing that psychosocial support buffers individuals from stressful events as and when they occur and not as an ongoing barrier to stress. Thomson and Schmied (2017) maintain that social support is deemed an important mechanism to buffer against stress and is widely recognised to enhance psychological wellbeing. Support can be divided in aspects of emotional support and practical support. Wheatley (1998, p.46) defines emotional support as "instances where reassurance, intimacy and the knowledge that one is loved and cared for are received, when advice is either sought from or offered by someone who can be confided in and relied upon for help". Wheatley (198, p.47) also defines practical support covering "all aspects of help that involves aiding an individual with a problem in a physical or 'doing' capacity". The significance of a support system and support environment can be seen to influence a person's adjustment to change and stress and this support can manifest as peers, family, professional and untrained helpers and services provided by society (Ball, 1994). Wheatley (1998, p.49) also states that, "It is a widely held opinion by health professionals that psychosocial support has a positive influence upon mental health

throughout the lifespan of an individual. During pregnancy its presence has been shown to significantly enhance women's emotional well-being".

Psychosocial Support Networks

Lederman and Weis (2009) maintain that researchers have extensively examined the effects of support that mitigate the physical and emotional strain experienced by women during pregnancy and postulate the type and timing of support has often been poorly differentiated. Weis' (2006) study of 421 women researched the relationship of community support and family adaptability to prenatal maternal adaption. It revealed the importance of a perceived network of support as early as the first trimester assisted in addressing fears surrounding identification of being a mother, childbirth fears and acceptance of pregnancy (Lederman & Weis,2009). Gan, Xiong, Song, Xiong, Yu, Gao, Hu, Zhang, Tian, Gu, Zhang and Chen's (2019) study researched the effect of perceived social support during early pregnancy (before the 16th week of gestation) on depressive symptoms at six weeks postpartum. Their study concluded that women with lower perceived social support during pregnancy may have an increased risk of depressive symptoms after childbirth and hypothesises that early intervention may assist prevention of depressive postpartum symptoms.

Carrick-Sen (2012) postulates that there is substantive literature on the role of the father and the partner relationship. Bilszta et al. (2008) cited in Carrick-Sen, (2012) reported on a study involving 1578 women, by which only 4 per cent of women were identified as single or unpartnered. They reported that women in a partner-relationship with poor partner-derived support were at increased risk of elevated antennal EPDS (Edinburgh Postnatal Depression Score) scores compared to single or unpartnered women suggesting that negative psychosocial influences were more detrimental to a women's experience than no partner at all. However, findings from a study exploring perceived partner support in pregnancy predicting lower maternal and infant distress showed that "involvement of and support from the baby's father during pregnancy is associated with improved maternal mental health",

providing “additional impetus for exploring prenatal partner support” (Stapleton, Schetter, Westling, Rini, Glynn, Hobel & Sandman, 2012).

Other primary sources of support include close relatives, good friends and with reference to pregnancy, health professionals (Wheatley, 1998). During the first trimester of pregnancy, a woman may “limit her pregnancy announcement to the father of the baby, her mother, and closest friends. It is this small network of friends and family that are most likely to provide intimate care, protection, and support nurturance” (Lederman & Weis, 2009 p. 212). Carrick-Sen (2012, p.283) noted that “occasionally, other members of the family or other health professionals are reported to be more supportive than the woman’s partner, as shown by Borjesson et al. (2004)”.

Ball (1994) postulates that whilst initial reactions to stress are primarily affected by factors associated with an individual’s personality or previous experience and expectations, the appropriateness (Currell, 1990) and the degree of sensitivity in which help is provided (Flint, 1986) by a professional helper can influence the situation. Therefore, help should be flexible in its approach and degree.

During a World Health Organisation (WHO) review of 85 prenatal clinical care guidelines, primarily from the United States, the United Kingdom and Canada, it was reported that some women found that perceived prenatal care felt respectful and comprehensive whilst others deemed the process to feel mechanistic or harsh (Chalmers, 2017). Chalmers (2017, p.25) states that, “women’s preferences emphasised a more psychologically supportive approach”. Historically, complaints recorded by Reid and McIlwaine (1980), O’Brien and Smith, (1981) and Hall et al. (1985) surrounding the experiences of antenatal support are mentioned by Sherr (1995) highlighting complaints that centered around poor levels of communication, disturbances in the continuity of care and a ‘production line’ like atmosphere resulting in depersonalization. Chalmers (2017) highlights recent specific needs that warrant addressing including preferences of being seen by a single provider, education and counselling throughout the course which was currently lacking in the women studied, decision making

involvement and receiving information regarding physiological and emotional changes in addition to common discomforts of pregnancy. She categorically states that, “simply offering routine, clinically focussed service provision is not sufficient; women need social, cultural and psychological support throughout” (Chalmers, 2017, p.25).

Jomeen and Martin (2005) highlight that the standard antenatal clinical practice did not screen for psychological distress during pregnancy (National Institute for Clinical Excellence (NICE), 2003). Research undertaken by Jomeen and Martin (2005) also noted that clinical concern was focussed mostly on post-natal depression and in turn argue that there is increasing evidence of psychological disturbance being significantly as prevalent and severe during the antenatal period. Their findings from studying 129 women at 14 weeks gestation highlighted that low self-esteem indicated by pregnant women could be an indication of other underlying psychological disturbances. The current NICE guidelines (2014, p.26) for antenatal and postnatal mental health: clinical management and service guidance state that “at a woman’s first contact with primary care or her booking visit… consider asking the following depression identification questions as a part of a general discussion about a woman’s health and wellbeing**”.** It is worth noting however that the updated NICE guidelines (2019, p.4) for antenatal care for uncomplicated pregnancies do not screen nor mention any emotional or psychological factors during the ‘first contact with a healthcare professional’ or ‘at booking (ideally by 10 weeks)’. McCauley, Abigail, Bernice and Van Den Broek (2019) articulate that healthcare providers are aware of the problem and the impact of poor maternal mental health and believe that healthcare providers recognise that maternal mental health should be continuously assessed from early pregnancy as early identification would aid early referral and treatment. My intention is to explore the experiences of emotional ambivalence during the first trimester of pregnancy regardless of a women’s mental health background as it can be perceived that women who experience ‘uncomplicated pregnancies’ may have their emotional needs overlooked during initial medical interactions.

Exploring even further out of the psychosocial support domain for relevant literature or research, I coincidently stumbled across a social media post @allontheboard (appendix 3). This image seemed to encapsulate the essence of experiencing emotional ambivalence in pregnancy and motherhood and sought a key message to seek support if deemed appropriate.

To summarise, it is clear from the literature and research studies that there is a degree of emotional ambivalence that women experience during pregnancy. Research goes further to correlate emotional and mental health difficulties that can have an adverse effect on the wellbeing of both mother and baby. The studies reviewed looked at the extent of emotional difficulties from a quantitative stance involving score-based questionnaires which may not have encapsulated the subjective and phenomenological experiences of the women studied. The literature and research surrounding psychosocial support during pregnancy also does not seem to encapsulate the lived experience of a women's perception of that support directly from the women's experience. It can be construed that it is not about what support is present but how that support is inherently received and perceived. This literature review suggests that the emotional and physical developments during the first trimester of pregnancy have almost been overlooked and further research is needed in this area to uphold women's subjective experiences of emotional ambivalence and perceptions of psychosocial support. This will give women a voice, a chance to reflect on and express their own lived experiences of their first trimester of pregnancy.

Chapter 3: Methodology

The purpose of this study is to explore the extent of emotional ambivalence a woman may experience and to examine the degree of psychosocial support that may or may not be there during the first trimester of pregnancy. Furthermore, the intention of this study is to potentially raise awareness for other women, social and professional support networks, counsellors and healthcare professionals to draw upon these experiences. This chapter aims to discuss the research paradigm and methodology chosen, how the participant recruitment and selection process was undertaken, the data collection process utilized and the steps taken to analyse the data. In addition, this chapter will explain how ethical issues were considered, and how validity and trustworthiness of the study was ensured.

Research Paradigm

The nature of this study's question and aims were best suited to be explored within the qualitative paradigm enabling the phenomenological experience of a women's first trimester of pregnancy and their perceptions of psychosocial support to be richly explored. It was considered that a qualitative study would "provide a 'deeper' understanding of social phenomena than what would be obtained from purely quantitative data" (Silverman, 2017, p.194). Porter and Robinson (2011, p.9) depicted the notion that phenomenological and existential hermeneutics harvests a discovery to understand "one's own finite situation". Exploring women's phenomenological experiences of the first trimester of pregnancy and their perceptions of psychosocial support has provided the opportunity for me to work as an open-minded researcher to uncover research findings as they unfold organically. Finley (2015) discusses the comparative similarities between a counsellor's process and a qualitative researcher's process as both seek to discover and explore the meaning and the understanding of how the world is experienced by an individual. Porter and Robinson (2011, p.9) discuss the underpinning research philosophy of Heidegger depicting the notion that humans are naturally

“existentially situated creatures” and already understand the world through interpreting circumstances and own practical involvements. I intended to choose a research approach that would facilitate the participant to explore their own experience.

Methodology: Interpretative Phenomenological Analysis

The paradigm of qualitative research methods underpins an explorative and descriptive focus that should not focus on attempting to obtain ‘universal truths’ but rather focus on attempting to achieve a “deeper understanding of the meaning of experience from the perspective of the participants selected for the study” (Mintz, 2010, p2). With human nature, the overall experience of pregnancy and perceptions of psychosocial support all being retrospectively phenomenally interpretative, I decided that Smith, Flowers and Larkin’s interpretative phenomenological analysis (IPA), a research methodology “strongly influenced by the hermeneutic version of phenomenology, would be the most appropriate research approach to facilitate drawing upon the participants’ unique experiencing (Smith, Flowers & Larkin, 2009, p.34). From the onset, I wanted to choose a research methodology that would preserve the participants’ account of their own experiencing; however, as I, the researcher, would be drawing upon the participants’ interpretations of their experiencing, the notion of ‘double-hermeneutic’ data analysis would be virtually impossible to avoid (Smith & Osborn, 2004). The IPA method directly involves a process of the researcher making sense of a participant who is presently making sense of their own phenomena (Smith, Flowers & Larkin, 2009). “IPA encourages the use of small samples and analysis on a case by case basis, leading to a discussion of differences across cases as well as common themes” (McLeod, 2015, p.146).

Sampling

A small-scale IPA research project recommends between three to six participants as sufficient to offer profound insights into sensitive topics (Finlay, 2015). Therefore, I set out to research

four women's experiences to provide data with enough depth and richness to analyse. I endeavoured to find a research sample that had a degree of homogeneity as noted within the IPA approach, with an intention to acquire perceptions based on the study's aims (Smith, Flowers & Larkin, 2009). Denzin and Lincoln (1994) suggest that many qualitative researchers seek out participants that have experiences within the processes that are being studied (Silverman, 2017). Purposive sampling was deemed necessary in order to ensure the parameters in which I intended to research could be set. I was mindful however that I didn't want to place any limitations on pregnancy outcomes to strengthen the study's validity; therefore, pregnancy outcomes and number of pregnancy experiences were not specified in the inclusion criteria.

I advertised my research poster (appendix 4) on the BACP's online research noticeboard and placed paper copies of the research poster across Chester University campuses using sensitively designed paper adverts that offered potential participants information on how to self-select and contact me, ensuring the participants had voluntarily opted in to the research project.

Five participants contacted me via the email address given on the research poster. Communication trails between each participant and I involved sending out an introductory letter (appendix 5), an information sheet about myself and the nature of the study (appendix 6) and an inclusion questionnaire to participate in the study (appendix 7) via the participants' preferred method of contact. The inclusion questionnaire indicated that I would find a purposive sample to ensure appropriate data would be collected for IPA analysis. The inclusion questionnaire also determined that the inclusion criterion for research would be met. The inclusion criteria comprised of the following:

- The participants were female and over 18 years of age
- The participants were not knowingly currently pregnant

- The participants had experienced pregnancy (the number of pregnancies and pregnancy outcomes were not relevant as this study was only looking at the first trimester of pregnancy experiences)
- The participants could identify experiencing a degree of emotional ambivalence during their first trimester of pregnancy
- The participants could identify perceptions of psychosocial support during their first trimester of pregnancy (such support may or may not have been sufficiently present)
- The participants could identify feeling sufficiently grounded to talk safely about their experience and had access to emotional support if needed throughout the duration of the research

Each participate successfully met the inclusion criteria and agreed to participate in the study. A date, time and venue were then mutually agreed for the semi-structured interviews and data collection to take place.

Data Collection

Data was collected from four participants through semi-structured face to face interviews that each lasted approximately one hour. Smith, Flowers and Larkin (2009) maintain that IPA requires a verbatim record of all data collected from the data collection process.

There was a fifth participant involved in this study, the first participant. Unfortunately, during the interview process, there was a malfunction with my recording device and only a sixth of the data was recorded. With additional correspondence with the participant via email, it was mutually agreed that I could use this experience as a pilot interview and reflect on the recording device's reliability and overall experience of the interview process (appendix 8). The pilot participant's recorded data and paperwork were immediately destroyed. Her words and

honesty were inspiring and humbling and contributed to motivating me to pursue collecting data.

Smith, Flowers and Larkin (2009, p.57) describe qualitative research interviews as a "conversation with a purpose" permitting "participants to tell their own stories, in their own words". Open ended, non-directive questions were asked that intentionally guided the 'conversation' that offered sufficient flexibility for follow up questions and/or probes that encouraged a greater depth to the interview responses (Saunders & Wilkins, 2010). I endeavoured to learn the interview schedule in advance to reduce any potential distractions that may get in the way of the interview as suggested by Smith, Flowers and Larkin (2009)**.** I used cues including, 'sitting here now…', 'based on what you said…', 'when you said this…', 'is there anything else you would like to add…' to gently guide the participants to adhere to the parameters of the question and also to facilitate drawing upon a richer response. There were six questions asked during the interview:

- Can you talk me through your pregnancy experience?
- Can you describe the feelings you recall during your first trimester of pregnancy?
- How did you manage those feelings?
- Did you tell anyone about your pregnancy during the first trimester? Talk to me about how this felt for you.
- During your first trimester, can you talk me through your experience of support?
- What support do you think would have been useful for you during this time?

The first three interview questions were designed to be semi-structured to encourage participants to freely speak about their personal experiences of emotions felt and the last three questions to encourage speaking about perceptions of support during their first trimester of pregnancy with reference to the aims of this study.

The interviews were recorded using a voice recording app and immediately downloaded onto my university One Drive storage. After the interviews had taken place, I invited the participants to choose pseudonyms to observe anonymity of identifiable information which they all proceeded to do. According to McLeod (2015), transcriptions can be deemed ethically safer, securing the notion of anonymity by replacing identifiable names and information with pseudo gestures.

Smith, Flowers and Larkin (2009) maintain that IPA requires a verbatim record of all data collected from the data collection process. I personally transcribed each participant interview. Each transcription was sent to each respective participant via email so that they could choose to ascertain if their transcription offered a true reflection of the interview alongside a sincere thank you letter for participating in the research study. I endeavoured to ensure that each participant understood that they were entitled to edit their transcripts if they deemed it necessary to and that they had the right to withdraw from the research study up until they had approved their transcriptions. The right to withdraw was mutually agreed by myself and the participants via email once the participants had had the opportunity to view and change their original transcription and had agreed for me to use the data collected to start my analysis work (appendix 9).

Data Analysis

Once all the interviews were completed, I listened to and transcribed each recording and took time to really try and hear each participant. When confirmation came through from each participant giving me permission to use their transcript, I set the transcript out as suggested by Smith, Flowers and Larkin (2009) with a space for exploratory notes on the right and a space for emergent themes on the left of the original transcript. I worked with one transcript at a time with the intention to solely focus on each participant's data. I embraced viewing each transcript from the 'bottom up' to gain a richer insight of each participant's expert and unique

view (Reid, Flowers & Larkin (2005). By doing so, I endeavoured to “capture the quality and texture of individual experience” (Willig, 2008, p.57). As a novice researcher, to sustain a “sense of manageability in the analytic process”, I took solace in fostering a six step data analysis process as suggested by Smith, Flowers and Larkin (2009, p.81). I maintained a positivist stance to the study during the analysis process to ensure the ‘facts’ were collected in an objective way in accordance with an inductive process (Flick, 2018).

Step 1: Reading and re-reading

I began the process of “entering the participant’s world” by reading the transcript and listening to the interview and then repeatedly reading the transcript, ensuring that the participant became the focus of analysis (Smith, Flowers & Larkin, 2009, p.82).

Step 2: Initial noting (appendix 10)

I had initially tried to digitally annotate the transcript, however I found it much more productive and creatively freeing to manually take notes and annotate the transcript using a colour coded system (green, purple, blue) denoting ‘descriptive, linguistic and conceptual’ comments as and when they stood out in the text as suggested by Smith, Flowers and Larkin (2009). As discussed previously, IPA data analysis expects the researcher to simultaneously attempt to interpret the data in a ‘double hermeneutic’ way by means of the participants making sense of their experiences whilst the researcher makes sense of the participant’s sense making (Finlay, 2015). I worked within the ‘double hermeneutic’ domain and subsequently noted any pattern changes of flow, tone, explanations, descriptions and contradictions that I noticed and took journal like exploratory notes adjacent to the transcript.

Step 3: Developing emergent themes (appendix 11)

I initially searched for emerging themes adopting the notion of hermeneutics at this stage drawing upon arriving at a plausible and comprehensive interpretation of the participant’s phenomena (Thurston, McLeod & McLeod, 2015) reflecting on my exploratory comments. I then turned back to technology and digitally siphoned out all key references of the original

transcript that correlated with the themes. I then chronologically ordered them and clustered them accordingly.

Step 4: Searching for connections across the themes

At this stage, I moved back to manually working with the condensed data and cut all individual emergent theme and transcript evidence and clustered related themes to attain subordinate themes (appendix 12). I then clustered and organised the subordinate themes and placed them under a super-ordinate umbrella that correlated with my aims of the research study.

Step 5: Moving to the next case

I repeated the analysis process for each of the three participants using their interview and transcript data.

Step 6: Looking for patterns across cases (appendix 13)

During this stage of analysis, I looked for patterns across all the superordinate and subordinate theme tables configured in stage four and five. I highlighted similar subordinate themes that were emerging across the combined data which led to “reconfiguring and relabelling” some themes (Smith, Flowers & Larkin, 2009, p.101). Some themes were also consequently combined or set aside at this stage. Four super-ordinate themes that encompassed thirteen sub-ordinate themes emerged from step six of the analysis process evidenced by transcript quotes of the participants’ narrative.

In chapter 4 of this study, findings from the data analysis are presented providing a thematic description relating to each participant’s lived experience of emotional ambivalence during the first trimester of pregnancy and their perception of psychosocial support during that time. Chapter 5 will address the findings from the data analysis and draw comparisons between them and the literature review from chapter 1.

Ethical Issues

I conducted my research in accordance with the BACP Ethical Guidelines for Research in the Counselling Professions (2019), alongside the Ethical Framework for the Counselling Professions (2018) and also in accordance with the University of Chester Research Governance Handbook (2016). Smith et al. (2009) note that any research project should start with the important point of avoiding the notion of harm.

My sampling strategy involved the participants self-selecting by contacting myself if they wanted to participate in my research study. All participants contacted me separately and independently via my university email address. All participants received a participant information sheet offering an overview of the nature of the study and completed an inclusion questionnaire. All participants also received a copy of the interview questions and engaged in a collaborative discussion to arrange a mutually convenient meeting time and place.

I endeavoured to explain the purpose and limitations of confidentiality that I could offer before commencing each interview in accordance with the BACP Ethical Framework for the Counselling Professions (2018). Each participant signed an informed consent form (appendix 14) and was given an opportunity to view the research information sheet, the scheduled semi structured questions intended to be asked and an opportunity to ask any questions they had before commencing the interview process.

As my research question had the potential to raise sensitive issues surrounding a women's experience of pregnancy, I clearly requested that the participant felt sufficiently grounded in order to talk safely about their experience and had access to sufficient emotional support throughout the course of their time taking part in the research study. This was made clear in the research information sheet (appendix 6) and was a part of the inclusion criteria and questionnaire (appendix 7), part of the general initial discussion before the interview and a part of the concluding debrief with the participant after the interview. I also gave the participants the opportunity to take a copy of the research advertisement poster (appendix 4)

that provided information for relevant support networks if they felt they wanted to pursue any support. During the interview process, I offered the participants the option to take a break if they wanted to at any time to provide opportunities to regulate their emotions or to ground themselves. All participants were also made aware that they could terminate the interview at any time.

I was aware that the sensitive nature of the study may have proved to be difficult to look at objectively at times, therefore I accessed support through my personal client supervisor and attended pre-arranged meetings with my dissertation supervisor throughout the course of the research study. I also kept notes in a personal journal highlighting difficulties with objectivity and subjectivity as they came up, as well as noting my personal experiences of the study.

All transcriptions were secured using a password protected system on my password protected laptop and stored on my university One Drive under the University of Chester's data protection guidelines. When the transcriptions were sent to the participants, I used a password censored attachment with a passcode sent separately via email (see appendix 9).

The interview audio recording and transcriptions data will be deleted from my university One Drive and my PC on completion of my MA qualification. Any electronic or hard copies of paperwork, other than the published research, will be destroyed (shredded or electronically deleted) after 5 years in keeping with the data protection act.

Trustworthiness and Validity

Yardley's (2000) criteria for assessing validity highlighted by Smith, Flowers and Larkin (2009) presents four principles for assessing the quality of qualitative research with specific reference to IPA. These principles are sensitivity to context, commitment and rigour, transparency and coherence and lastly, impact and importance.

The nature of my research question and aims originated from my own personal experience of first trimester pregnancies. My interest set a strong context as a motive for this study to take place. Exploring and declaring my reasons as the initial step to calibrate myself as a “research instrument” ascertained the initial direction in which the study began (Saunders & Wilkins, 2010).

I committed to adhering to transparency and coherency throughout the study following the suggested IPA structure as suggested by Smith, Flowers and Larkin (2009). The literature review created a solid platform for this study, adding to the studies validity. I have intended to be transparent throughout the course of the research project and highlighted my interests, biased views, assumptions and influences by bracketing and checking my interpretations when looking for common themes (Mcleod, 2011). Progoff (1975) cited by Johns (2012, p.130) describes the journaling process as a means to explore “one’s life from many perspectives, finding connecting threads, linking past and present and making meaning through reflection”. I anticipated being a reflexive researcher on the understanding of increasing my self-awareness from a researcher role and a personal stance. Saunders and Wilkins (2010) endorsed reflexivity to help through difficulties, facilitate self-reflection and to act as a record to highlight personal biases that may have an influence on the research study.

To ensure validity and trustworthiness of the study, I used verbatim extracts giving participants their voice during the data analysis process. I kept records of every part of the study and kept a thorough paper trail to show my ‘workings’ (see appendix 1 - 14). All participants were invited to engage in ‘member checking’, to review their transcriptions and edit them if they desired to determine their lived experience had been accurately presented (Creswall & Miller, 2000).

The research study endeavoured to offer an opportunity for the participants’ experiences of emotional ambivalence and perceptions of psychosocial support to be heard and explored; that may later contribute to having an impact on research readers who may want to further explore addressing the issue of support for women during their first trimester of pregnancy.

Chapter 4 – Findings

Overview

This chapter aims to provide a thematic description of the participants' lived experiences of emotional ambivalence and perceptions of psychosocial support correlating with the studies research aims. In this chapter I will present participant profiles offering relevant background information about their pregnancy experiences. I will then present the relevant findings from this study outlining themes that were identified to be common for all four participants as discussed in chapter 3. The study analysis identified four super-ordinate themes which encompassed thirteen sub-ordinate themes (see table below). These findings will be presented and evidenced using material taken directly from the primary data clustered from the analysed interviews.

Participant Profiles

Each participant was asked to choose a pseudonym to endeavour to ensure anonymity. Each participant was consistent in meeting the inclusion criteria (see chapter 3).

Ann experienced one unplanned pregnancy and is a single Mum to a child under five years old.

Louise has three children and has experienced three planned pregnancies. She shares two children, aged between 11 and 13 years old with a previous partner and shares her youngest child with her current partner.

Melanie has experienced five planned pregnancies and has three young children with her husband. She experienced two early miscarriages between delivering her first and second children.

Kate has experienced two pregnancies and has two children between the ages of 8 and 13 with her husband. Kate describes one of her pregnancy experiences as a ‘pleasant surprise’ (Kate, 7-8).

Themes

Super-ordinate Themes	Sub-ordinate Themes
1. Emotional Experiencing	*1.a. Recollection of positive feelings*
	1.b. Recollection of negative feelings
	1.c. Isolation
	1.d. Pregnancy as a phenomenological experience
	1.e. Fantasy vs reality and resentment
2. Ambivalence	*2. Ambivalence*
3. Perceptions of support	*3.a. Significant relationships*
	3.b. Other aspects of support
	3.c. Perceptions of absent support
4. Missing needs	*4.a. Emotional holding*
	4.b. Continuity of support
	4.c. Clarity
	4.d. Individual-led support

I will be presenting the super-ordinate themes and sub-ordinate themes in the order above. I will give a brief overview of each theme and present direct evidence using the participants' quotes from the transcribed interviews. Quotes will be italicised and referenced with the participant's pseudonym and line number(s) from each participant transcription. Some transcript quotes have been condensed for coherency purposes and '…' have replaced the original text. All names (including significant others) and any other identifiable information have been allocated pseudonyms to adhere to confidentiality requirements.

Super-ordinate and Sub-ordinate Themes

Superordinate Themes and Subordinate Themes	Ann	Louise	Melanie	Kate
Emotional Experiencing				
Recollection of positive feelings	yes	yes	yes	yes
Recollection of negative feelings	no	yes	yes	yes
Isolation	yes	no	yes	yes
Pregnancy as a phenomenological experience	yes	yes	yes	yes
Fantasy vs reality and resentment	yes	no	yes	yes
Ambivalence				
Ambivalence	yes	yes	yes	yes
3. Perceptions of support				
3.a. Significant relationships	yes	yes	yes	yes
3.b. Other aspects of support	yes	yes	yes	yes
3.c. Perceptions of absent support	yes	yes	yes	yes
4. Missing needs				
4.a. Emotional holding	yes	no	yes	yes
4.b. Continuity of support	no	yes	yes	no
4.c. Clarity	no	yes	yes	yes
4.d. Individual-led support	yes	yes	yes	no

1. Emotional Experiencing

All of the participants interviewed experienced a host of emotions in relation to their first trimester of pregnancy. Due to the nature of experiencing pregnancy and the circumstances surrounding the participants' lives during the time of the first trimester, both positive and negative recollections of emotions were identified.

1.a. Recollection of Positive Feelings

Ann, Melanie and Louise recall positive feelings. Ann expressed her happiness of being pregnant by describing a sensation of completeness of herself:

> *'Not being a mum was kind of a missing piece of me, it was kind of like a piece that I kind of always wanted' (Ann, 55-56)*

> *'It felt to be pregnant felt so right it felt like it was it was like meant to happen' (Ann, 58-59)*

Melanie also expressed that sense of completeness:

> *'When I did find out I was pregnant I was made up…that's all I ever want' (Melanie, 4)*

Melanie also described a sense of ease and contentment when she found out about her first pregnancy:

> *'I was made up, it was my first pregnancy and you think everything's rosy and it just happens and that's the way it is' (Melanie, 102-103)*

This contrasted with her sense of relief with her other experiences after having difficulty trying to conceive:

> *'I was like thank God for that' (Melanie, 91)*

Louise recalled her feelings when she discovered she was pregnant with her third child with her current partner:

> *'I felt a sense of emotional delight' (Louise, 169)*

> *'I just think I just felt so delighted to be pregnant' (Louise, 56)*

'We were initially very excited, that's almost your first trimester up' (Louise,332)

Kate initially described both her pregnancy experiences as:

'They have been positive experiences' (Kate, 2)

1.b. Recollection of Negative Feelings

For Kate, finding out that she was pregnant was unexpected. She was in the process of working her required notice at work and was about to embark on a new career within a sales company. Therefore, when Kate discovered that she was pregnant she recalls her feelings at the time:

'I think the absolute and utter shock of finding out I was pregnant' (Kate, 9-10)

'completely broke down erm with sadness' (Kate, 16)

'I was just floored, completely floored' (Kate, 18)

Kate also spoke about how she felt before she told work about her pregnancy:

'I know this secret and I can't say anything and, I just felt a bit ashamed' (Kate, 151-152)

Louise expressed feelings of fear, pressure and responsibility during the first trimester of pregnancy with her third child:

'I was thinking you know I was fearful of what it would be like to deliver a baby if I was going to deliver a baby' (Louise, 49-50)

'I just felt intensely there was a pressure that I never felt with the other two that you could be doing something very wrong for your family life in the sense that if something if the baby dies or there is a complication or you have got so many other people to think about' (Louise, 170-172)

'I did feel responsible…I felt responsible because I was physically carrying the baby' (Louise, 175-176)

'I can't get stressed because that might affect the baby' (Louise, 177)

'The baby is delicate; it is all precious and you are almost carrying like a Fabergé egg like you know it just felt very vulnerable and I felt an extra sense of responsibility' (Louise 210-212)

Melanie spoke about negative feelings that evolved from her previous experiences of pregnancy/birth complications and pregnancy loss:

'I was more nervous because of Oscar' (Melanie, 9)

'I was really nervous' (Melanie, 10)

'I was just really concerned' (Melanie, 14-15)

I was very depressed with this one already I was very negative I was on anti-depressants from the beginning erm I was very low' (Melanie, 187)

'I was quite negative about it I wasn't hopeful with it anyway' (Melanie, 128-129)

'It was just really hard for me' (Melanie, 28)

'I was so anxious this time when I found out I was pregnant' (Melanie, 43)

1.c. Isolation

Ann, Melanie and Kate expressed a feeling of isolation during the first trimester of pregnancy. Ann spoke about starting her pregnancy journey on her own from the onset due to not wanting a relationship with the baby's father:

> *'This thing of feeling very alone, very much like I had a fight on my hands, to be able to find a way forward' (Ann, 15-16)*
>
> 'The decision of, you know, I am going to do this alone, the loneliness that that kind of brought with it' (Ann, 78-79)
>
> 'compounded that kind of feeling alone' (Ann, 98-99)

Kate expressed a sense of loneliness when finding out about her unexpected pregnancy:

> *'I found out all on my own' (Kate, 16)*
>
> *'it did make you feel quite alone trying to manage everything' (Kate, 167)*

Melanie spoke about her experience of pregnancy loss and expressed a true sense of isolation when trying to make sense of it:

> *'dealt with it on my own' (Melanie, 36)*
>
> *'I was basically fighting with my brain to not get in that black hole and you're fighting by yourself out of it' (Melanie, 142-143)*

1.d. Pregnancy as a Phenomenological Experience

All participants highlight and acknowledge that pregnancy is a phenomenological experience and spoke about the uniqueness of their own experiencing:

'It was such a nice thing to share with my sister that we were both pregnant at the same time and although our pregnancies were so different… we shared that at the same time but in so different situations and we both were having to deal with things externally that were so different but at the same time the thing that meant so much to us was our babies' (Ann, 60-65)

'I've had three well very different pregnancies' (Louise, 2)

'I always knew that every pregnancy would be different but I was surprised and I am still surprised at how different experiences' (Louise, 385-386)

'I never anticipated that being pregnant three times would be worlds apart' (Louise, 391-392)

'Everyone is different and everyone handles things differently' (Melanie, 215)

'I think maybe with your second pregnancy, you kind of expecting a little bit more because you've been through it once' (Kate, 4-5)

1.e. Fantasy vs Reality and Resentment

Melanie, Kate and Ann all expressed predetermined conceptions that didn't manifest in their lived experiences:

'I just thought you get pregnant and that's it, you tell everyone, nothing goes wrong it's just dead smooth' (Melanie, 6-7)

'like what you want from the movies, it wasn't you know, the best sort of erm finding out I was pregnant experience' (Kate, 36-37)

'I envisaged the fairy tale, I envisaged meeting a man, falling in love, getting married then getting pregnant and all the rest of it where as it was just so far removed' (Ann, 81-83)

For Melanie, when her lived experience didn't manifest into *'nothing goes wrong'* and not being *'just dead smooth'* (Melanie, 6-7) she recalled two distinct experiences of resentment towards others:

> *'I felt angry as well seeing people outside the ward… outside smoking pregnant and… drinking and I'm like how are they having all these kids and I can't' (Melanie, 109-110)*

> *'You are just sitting there with young girls who want abortions so they are all like happy and they are not concerned, and you're sitting there sobbing your heart out because you are about to say goodbye to this life that you thought you are going to bring into the world' (Melanie, 25-27)*

Likewise, for Ann, when her lived experience didn't manifest into *'falling in love… then getting pregnant' (Ann, 82)* she spoke a felt sense of resentment towards others:

> *'I felt resentful for that as well… I found myself looking at families and mums and dads and babies and kind of thinking, but why haven't I got (mm) that kind of experience' (Ann, 26-27)*

2. Ambivalence

Although it has been significant to present the emotional experiences felt by all four participants, a key to this study is to explore the emotional experience of ambivalence. To recap, emotional ambivalence can be defined as "a particularly complex emotion characterized by tension and conflict that is felt when someone experiences both positive and negative emotions simultaneously" (Friedman,2014). All four participants presented emotionally ambivalent experiences.

Ann, Louise and Kate describe sensations of emotional ambivalence stating:

'I was very very torn and very kind of, I don't know, in a strange place' (Ann, 30-31)

'I was stuck in the middle' (Ann, 103)

'I had very strange emotions' (Louise, 59)

'It just was like a whirlwind' (Louise, 174)

'tore me down the middle' (Kate, 13)

'two different lives I was leading at that point which was very confusing' (Kate, 141-142)

Ann spoke about feeling opposite emotions simultaneously recalling:

'I remember kind of the feeling of 'oh my god it's happened', the elation, the kind of like 'oh yey', this has happened to me, and also the bit of, you know feeling scared as well at that point' (Ann, 32-33)

Melanie also recalled:

'I was a bit anxious when I found out I was actually pregnant I was ecstatic I was made up it was an amazing feeling' (Melanie, 104-105)

Louise also relayed feeling opposite emotions simultaneously stating:

'The initial excitement of being pregnant was quickly like literally within days swallowed up by this fear' (Louise, 158-159)

'in as much as elation to 'oh my gosh' but now this is real, we need to think about what could possibly go wrong' (Louise, 166)

Kate refers more abstractly to her experience of ambivalence, recalling:

'Any kind of positive things were building in me were constantly capped by these, you know negative thoughts' (Kate, 156-157)

Ann spoke about a feeling of displacement during the first trimester of pregnancy:

'Especially that first bit of pregnancy, it felt very kind of manic and very like I didn't quite know it was like 'oh my God' and I was jumping from thing to thing from emotion to emotion' (Ann, 196-198)

Kate also experienced:

'*realising the elation and then suddenly having to be this worker again' (Kate,104-105**)***

'One minute I'm talking to my mate about… this massively new experience that I was going through and then the next minute I've got to completely forget it all because I'm this completely other person' (Kate, 114-115)

Ann spoke about external circumstances that influenced her emotional mindset that led to her also experiencing emotional ambivalence:

'I was very happy about being pregnant but not happy about the circumstances 'cause I knew that I didn't kind of want to be in a relationship with the father' (Ann, 4-5)

'It brought up a lot of erm feelings really and it was that thing of being happy about being pregnant but really unhappy about knowing that I was erm you know going to be a single mum' (Ann, 6-7)

'I kind of knew that me and the baby would be ok together but everything else was just thrown completely in the air and I felt scared' (Ann, 51-52)

Kate also spoke about how making a choice not to tell work colleagues influenced her experience of ambivalence:

> *'I'd pretend that I was a 't-totaller'… that was a big pretence… was quite a lot of lies…There was quite a lot of lies which made you (me) feel very guilty that time at the same time me and Jeff were really starting to get excited and happy' (Kate, 82-84)*

Kate, Ann and Louise spoke about their relational cohort and how that played a role in feeling emotionally ambivalent:

> *'I was actually made up I suppose I was I was excited and thinking you know but none of my friends had babies' (Kate, 66-67)*

> *'When I was first pregnant,… that was quite a double edged thing because they were kind of happy for me willing me on kind of saying it'll kind of be ok but at the same time, I was very much aware that my two closest friends, they wanted to be pregnant themselves and they'd been through various IVF and whatever and so it was almost like I felt like had to almost apologise for being, for being in the situation' (Ann 172-175)*

> *'I was just initially absolutely elated but straight away as much as Stuart's initial response was overwhelming emotion, he was just so fearful that something could go wrong that I felt it definitely intensified my feelings of 'oh my gosh' something could really go wrong' (Louise, 162-165)*

All four participants spoke about noticing that although they were experiencing a plethora of emotions, positivity overtook any other feeling:

'Maybe the baby doesn't deserve to come into all this mess and it kind of left me with all that, but really the overriding thing was that I was happy to be pregnant and I was happy to be having a baby and I was happy to be becoming a mum' (Ann, 164-166)

'The feelings of being happy were quickly taken over by the worry the feeling of being happy never left' (Louise, 167-168)

'Even though the emotions and physically it was much more stressed it still left in my head and in my heart a very positive experience' (Louise, 179-180)

'I was a little bit anxious but really, really happy' (Melanie, 11)

'As I say, at the time, quite negative feelings at first then, we actually got our heads around it and felt you know quite positive' (Kate, 68-69)

In contrast, Kate and Ann also recalled:

'*I felt very guilty about feeling the negative feelings I was having erm I felt like I wasn't allowed to feel excited or happy' (Kate, 168-169)*

'Although I did feel happy, it didn't kind of seem like that' (Ann, 147-148)

3. Perceptions of Support

It can be considered that experiences of support can be believed as pivotal in any experience that is deemed emotionally stimulating. Therefore, understanding the participants' perceptions of psychosocial support was paramount to this study. The participants' experiences have been grouped together accordingly:

3.a. Significant Relationships

Partners

All four participants spoke about having some degree of a support network during the time of their first trimester of pregnancies. All participants spoke about a primary support group with reference to the baby's fathers, family members and key friendships, all with different degrees of support felt.

Louise spoke generally about having a positive perception of support:

> *'I had positive relationships that had enriched my emotional needs' (Louise, 187-188)*
>
> *'I think I always felt emotionally support' (Louise, 371)*

All participants spoke about the perception of support in relation to their partners:

Kate spoke about her and her husband's relationship:

> *'Me and Jeff have got a very open communication' (Kate, 170)*
>
> *'From a support point of view, Jeff has always been fantastic anyway at everything we've gone through' (Kate, 270)*

Louise spoke about her perception of support from her previous partner for her second pregnancy:

> *'I didn't feel like I was going to get the support I wanted or needed and that was always playing on my mind…I did have a large support network of friends and relatives and family so it never really manifested itself as a problem to me' (Louise 77-78)*

And her current partner for her third pregnancy:

> *'My relationship with Stuart is a much stronger relationship well is the strongest relationship I have ever had' (Louise, 32-33)*
>
> *'I felt that sense of shared responsibility' (Louise, 148a)*

'I had such a strong relationship with Stuart in our pregnancy so at no point did I ever feel this is more than what we can cope with' (Louise, 198-199)

Melanie spoke honestly about her and her husband's shared experience of loss and the struggle to support each other:

'He was supportive but he was in his own, we support each other the best we can but we don't always understand what each other is going through so I don't understand how he felt when we lost the first one and he didn't understand how I felt feeling your tummy grow and having all those sicky hormones and being sick every morning' (Melanie, 191-193)

Ann openly reflected on her experience with the baby's father and perceived no support due to the nature of their relationship:

'It was an unplanned erm pregnancy I hadn't known the father for for very long so it wasn't we were in a stable relationship' (Ann, 2-3)

'I was quite scared about mine and my baby's safety because of the Dad' (Ann, 23)

'I almost had to batten down the hatches with him erm and kind of try and off set from the very beginning how things were going be' (Ann, 187-188)

Other Significant Relationships

Louise, Kate and Ann made reference to other relationships that they perceived as a source of support. Louise discussed choosing to tell her friend:

'I wanted to have some level of support and I did talk to her about like the happiness of it and the anxieties I was feeling' (Louise, 219-220)

She also spoke about telling her current partner's parents and the support she hoped for from them:

> *'Even if things did go wrong… they would probably be the people we would be telling anyway' (Louise, 224-225)*

> *'When you are delighted and you want to scream from the rooftops you get that feeling from telling those people because they were excited for you so you still got that fulfilment' (Louise, 233-234)*

Kate spoke about two significant friends she confided in:

> *'My best was the first person I told' (Kate, 193)*

> *'I decided to ring my best friend… she calmed me down' (Kate, 19-22)*

> *'Told a friend….met her and confided in her because you felt so alone' (Kate, 76-77)*

Ann recalled her main source of support during the first trimester of pregnancy:

> '*The main source of support that I had at that point was the Dad's Mum' (Ann,130-131)*

> *'I could speak to her and she could understand what I was saying, what I was going through' (Ann, 133)*

3.b. Other Aspects of Support

All participants shared some insights into their experiences of other aspects of support.

Work

Louise, Kate and Ann all mentioned places of work when reflecting on their perceptions of support.

Louise spoke about not informing work during the first trimester:

> *'wanted to enjoy the bubble of the niceness before we had to do anything formal' (Louise 231-232)*

Kate describes her internal battle about falling pregnant during a period of transitioning jobs:

> *'you (I) kind of feel shamed at that point I suppose and think God, what is everybody going to think of me, what is everybody going to say they are all going to basically the biggest thing for me was I felt like everybody was going to know that I knew when I took the job' (Kate 131-133)*
>
> *'the shame of feeling that yeah was gonna let them down' (Kate, 145)*
>
> *'No support there because they didn't know I suppose in a way looking back that was my choice' (Kate, 248-249)*

Ann felt a solid sense of perceived support from her work place:

> *'The only place that kind of did feel ok and kind of safe and kind of like a place that I could kind of be was work, which seems like quite strange and probably strange to a lot of people but it kind of felt like nothing had changed there' (Ann, 203-205)*
>
> *'The one place that I did feel safe and protected was at work' (Ann, 207-208)*
>
> *'a big weight took of my shoulders' (Ann, 215)*

Medical/ Health Support

Both Melanie and Kate similarly described their perceived experience of medical support as:

'Everything is so clinical from a medical stand point' (Kate, 348)

'It was very clinical and nothing, no support' (Melanie, 20-21)

Melanie spoke comprehensively about having both positive and negative perceptions of support during her pregnancy experiences. She recalls one particularly distressing time when she felt she was supported:

'I just had a meltdown but luckily, I had a nurse who was just hugging me… she was the only one that I felt was supporting me everyone else it was just procedure…she was only one who actually gave me a hug and said everything will be ok' (Melanie, 51-53)

She also recalled times that she didn't feel emotionally supported. Melanie openly spoke about her experience when she found out she had no baby during a routine scan during the first trimester of pregnancy:

'They basically questioned me on why do I think I'm pregnant…just asking loads of stupid questions' (Melanie, 12-14)

'I felt like they thought I was lying about the whole experience that I had the way they were questioning me' (Melanie, 105-106)

'There was no support, we were basically handed over a tissue and that was about that the most support that you got' (Melanie, 22)

'There is no support, there is no advice nothing just a piece of paper saying this is what is going to happen you' (Melanie, 33-34)

Ann described how she tried to seek emotional support via the GP and mental health services. Her experience concluded with her not receiving the support she needed:

> *'I also went to my GP about counselling but their thing was that I wouldn't get seen, the waiting lists were quite high and I wouldn't get seen for quite a while' (Ann, 119-120)*

> *'I also spoke to the mental health services and got a referral through to them but when they asked what it was I wanted at that time, in the beginning bit of the pregnancy, I wasn't sleeping very well and most of it was due to all the things that were kind of happening at the time but it was making me feel even more anxious. So really what I was saying to them was if I can just sleep, but they were like we can't give you anything there was nothing that they could give me' (Ann, 121-125)*

Kate couldn't recall a time that she was offered emotional support from the GP:

> *'I don't remember any conversations about what's going on for, y'know how are you feeling' (Kate, 350-351)*

External Agencies

Louise, Ann and Melanie shared perceptions of support relating to external agencies outside the parameters of medical and health care.

Louise spoke about not needing any additional emotional support:

> *'There was no part of me that ever felt I needed a sense of psychological support in addition to what I was getting' (Louise, 368)*

For Ann, she sought support via the family support unit regarding her experience of domestic abuse during the time of early pregnancy and recalled her experience:

'I remember going to the family support unit and that was when I was five weeks pregnant and I remember, and I still always remember the woman saying to me when we went through all what was happening and whatever, and her advice was to actually not go through with the pregnancy' (Ann, 110-111)

'they helped me with practical things erm they didn't they didn't give any emotional support erm at all it felt very much the opposite erm there was no kind of it was like your emotions of being erm happy about being pregnant were dismissed' (Ann, 167-169)

During the interview, Ann really expressed a sense of desperation to seek emotional support and tried to seek that support from many avenues. Her sense of desperation was highlighted when she expressed:

'I'm screaming out for help and no-one is listening' (Ann, 128)

For Melanie, after her pregnancy losses and during her times of early pregnancy thereafter, she believed:

'there was nothing out there no one to talk to even like someone who has gone through the same to help you there's no like a group or anything' (Melanie, 97-98)

3.c. Perceptions of Absent Support

All participants recollected some aspect of support that was absent from their experience during the first trimester.

Louise spoke about her diminished work-related support base due to moving jobs and diminished friendship relationships in her life:

'My support network had really minimised because I had had moved work teams' (Louise, 185)

'I just had different relationships with people and lot fewer relationships' (Louise, 187)

Kate spoke honestly about her family's approach to managing feelings:

'I did tell my mum but she wasn't the first person erm yeah me and my mum, we've always been the family that don't talk about feelings you now we don't really sort of go down that road' (Kate, 201-202)

Ann candidly spoke about missing her relationship with her Mother who had sadly died:

'It kind of brought a lot of feelings back of when my Mum died' (Ann, 92)

'I missed her at that point' (Ann, 96)

'I wanted her to tell me about you know when she was pregnant with me and what happened and you know it's ok that's normal to come with me for the scans and stuff and so it felt very much it felt very I did feel very alone' (Ann, 93-95)

Ann also recollected feeling like she couldn't confide in her sister as her sister was managing a diagnosis of cancer whilst pregnant during the same time:

'I felt like the next closest person to that was my sister and we did share everything together and even like the pregnancy, but it even felt then I couldn't then talk to her about my feelings of this when she was going through…' (Ann, 97-98)

Melanie reflected on feeling that she had no-one in her family to understand her felt sense of loss:

> *'No one to talk to… my mum didn't understand it because her pregnancies have been fine no one in the family has had miscarriages so there was no one to understand it was yeah so I was on my own' (Melanie, 115-116)*

4. Missing Needs

Each participant was asked the question 'what support would have been useful' during their first trimester of pregnancy. This question was designed to enable the participants to reflect on their experiences and perceptions of support and share any missing needs that may have been useful to enhance their experience during their experiences of the first trimester. All participants spoke about some missing needs that they felt they had during that time and spoke about concepts of support that could have been considered useful at the time to enhance their personal experiences.

4.a. Emotional Holding

At various points, Kate, Melanie and Ann labelled a missing sense of emotional support by means of emotional holding.

Kate spoke about needing someone who could offer her more of an emotional connection:

> *'I needed somebody a bit more emotional' (Kate, 205)*

Melanie directly recalled feeling that there was no-one or no place to go and talk through her experience of pregnancy loss at the time that it was happening:

> *'no one to talk to' (Melanie (116)*

'not having a place to go, not putting it to rest' (Melanie, 138-139)

Ann also identified that she felt there was no-one or no place to go to talk and verbally express her emotional experiencing recalling:

'It was more emotional support that I thought that I needed' (Ann, 233)

'There's nobody that I could tell where it would just be 'yey' I'm pregnant and that's the kind of support that I that I kind of missed or being able to go anywhere and just talk' (Ann, 177-178)

'I had no one to kind of speak to about that being so scared I suppose' (Ann, 238)

All three participants spoke about a need to have their thoughts and emotions held or placed in some capacity. Kate and Ann metaphorically described their emotions and spoke about wanting support to assist in managing these feelings:

'no one to tell… or just share it with or just to hold that bubble for a minute please, because it's weighting me down, weighting me too much' (Kate, 310-312)

'There was nowhere to kind of express that kind of thing of I have got ten spinning plates going on and I don't know what to do' (Ann, 189 – 190)

Kate also felt that it would be have been beneficial for her to have someone to assist her in balancing the ambivalent feelings she felt:

'someone… to sort of shrink the negative things and be able to sort of expose the positives more, you (I) would be able to sort of feel that your (my) experience was so much better' (Kate, 330-331)

Melanie made specific reference to desiring a professional body to support in gathering her thoughts after hearing that she had lost her baby:

> *'get your thoughts together with maybe a counsellor or a nurse that can be a bit supportive and just talk to you for a minute' (Melanie, 202-203)*

4.b. Continuity of Support

Louise and Melanie both addressed feeling continuity and consistency of support was missing during their experiences.

Louise spoke about experiencing a consistent team of midwives throughout her pregnancy journey with her first two pregnancies.

> *'in my previous experiences because it had been a small team of three midwives every appointment that I went to it was the same people' (Louise,125a-126a)*

She highlighted a contrast in support noticing that she didn't have any one person within the medical and health profession during her last pregnancy to attend to her needs which she noticed added to her anxiety:

> *'Actually, I never had any one person that I could build a rapport with' (Louise, 124a-125a)*
>
> *'that added to my anxiety, the fact that I didn't have a consistent team' (Louise, 131a)*
>
> *'I would of emotionally liked to have had the same team' (Louise, 133a)*

Melanie also discussed the notion of desiring a more consistent level of support with reference to one specific person within the medical and health profession to attend her needs. She also made specific reference to coveting a one to one support right from the onset of pregnancy:

'I think it would be good to have a one on one person that can build a relationship with you…to know you and understand your situation' (Melanie, 249-251)

'I think you should have a one on one from the very beginning so that they can understand you as a person and how you are' (Melanie, 255-256)

4.c. Clarity

With pregnancy being renowned as a new and phenomenological experience with specific reference to first time and/or first hand experiences, three participants spoke about their experiences that left them feeling that they needed more information regarding their situations.

Melanie recalled what she needed directly after hearing about her pregnancy losses:

'Some kind of area to be able to speak and get your thoughts together because I didn't understand what was going on' (Melanie, 211-213)

Kate spoke about the uncertainty of routine medical involvement during pregnancy stating:

'You feel like a complete duck out of water no one really prepares you' (Kate, 231)

'It should have been a bit more explained' (Kate, 235)

'From a preparation stand point you need to I think that needs to be looked at a little bit more from my experience' (Kate, 246-247)

Louise also spoke about being unclear about expected routine medical involvement with her third pregnancy:

'I had no anticipation of how regularly you see the midwife do you only see them twice for the first trimester and then only once in the second there is no kind of what a pathway looked like and I think some kind of schedule in my head'(Louise, 323-325)

4.d. Individual-Led Support

Louise, Melanie and Ann all make reference to specific needs that they would have liked to have had supported. Not only do these needs highlight what was important to the participants during the time of their first trimester of pregnancy, but they also highlight what they felt they needed as individuals during their unique experiences.

Louise discussed accessing information about antenatal procedures as and when she desired it:

'I suppose knowing the information is there and I can access it if I wanted to, even if they said, your first trimester you are going to have a scan and if you want we can give you some information about what to expect at that scan and at your second trimester you are going to have this and you are going to have a more in depth scan and if you want I can provide you with some booklets of what that is going to entail' (Louise 363-367)

Ann spoke about what she explicitly needed from the family support unit assisting her in her experience of domestic abuse during the time of pregnancy:

'What I wanted all along was for them to say it'll be ok you will be safe we will make you safe or we will help make you safe we will help you out' (Ann, 156-157)

Melanie spoke at several times during the interview about a desire to have her needs respectfully met as an individual whilst going through her own unique experiencing of pregnancy and pregnancy loss. Melanie stated that:

> *'It would have just been nice to have been treated not so routinely' (Melanie, 222)*

Melanie spoke how she didn't feel like she was treated as an individual:

> *'I wanted to have an early scan because I was so nervous, they just wouldn't consider it' (Melanie, 98-99)*
>
> *'the hospital was not understanding my background and was not willing to help' (Melanie, 187)*
>
> *'one rule for everyone kind of thing' (Melanie, 188)*
>
> *'they were sticking to the rule book' (Melanie, 201)*

She also spoke about the management concept of women who have just been told about their pregnancy loss during a scan procedure:

> *'Instead of leaving the scan room and going back in the waiting room, with all the babies and the mums pregnant, going to a separate room, a relaxation room where there is a nurse or counsellor or just anyone just to sit and support you and give the information sheets out, go through it with them, explain it, talk to them like this is not your fault this happens' (Melanie, 228-230)*

To summarise, these findings have highlighted aspects of emotional ambivalence and perceptions of psychosocial support experienced by all four participants. The next chapter will

explore these findings further in the context of the research and theory discussed in chapter two.

Chapter 5: Discussion

Overview

This chapter aims to draw together the outcomes delivered from the findings in chapter 4 and the previous and relevant literature reviewed in chapter 2. This chapter will ascertain the outcomes which either corroborate or contradict the literature reviewed. The analysis from this qualitative study generated four superordinate themes. These themes will be used as headings for this discussion:

1. Emotional Experiencing
2. Ambivalence
3. Perceptions of Support
4. Missing Needs

Specific quotes from the participant's transcribed data will be presented in brackets and italicised e.g. Melanie (*22-23*). Numbers and letters in brackets will refer to superordinate and subordinate themes derived from the data analysis e.g. 1.a. = super-ordinate theme '1' (emotional experiencing) and sub-ordinate theme 'a' (recollection of positive feelings). The table below is a guide of all super and sub-ordinate themes.

Super-ordinate Themes	Sub-ordinate Themes
1. Emotional Experiencing	a. Recollection of positive feelings b. Recollection of negative feelings c. Isolation d. Pregnancy as a phenomenological experience e. Fantasy vs reality and resentment
2. Ambivalence	
3. Perceptions of support	a. Significant relationships b. Other aspects of support c. Perceptions of absent support
4. Missing needs	a. Emotional holding b. Continuity of support c. Clarity d. Individual-led support

Emotional Experiencing

In 1.a. and 1.b. all four participants recollected positive and negative feelings during their first trimester which corroborates with Mullin's (2005) description of dramatic and fast paced experiences of changes including physical, emotional and social undertaken by a woman during pregnancy. Experiences of sheer elation (1.a.) were described as completeness by Ann (*55-56*) and Melanie (*4*), a 'positive experience' by Kate (*2*) and 'emotional delight' by Louise (*169*). Negative experiencing (1.b.) included pregnancy unexpectedness (Kate, *9-10*), former experiences of pregnancy loss and complications (Melanie, *9, 10, 14-15, 187, 128-129, 28, 43*) and anxiety from the responsibility of carrying a baby (Louise, *175-176, 177, 210-212*). Participants across the sample spoke of the uniqueness of their experiences of pregnancy (1.d. and 1.e.) not only as a phenomenological experience for each participant (Melanie, *215* and Ann, *60-65*) as denoted by Hunter (1994) and Levesque-Lopman cited in Mullin (2005), but also as a phenomenological experience for each pregnancy (Louise, *385-386, 391-392* and Kate, *4-5*). Melanie (*215*) points out that everyone is different and everyone handles things differently which corroborates with Leff's (2005) suggestion that each parent responds differently and the underpinning philosophy of Rogers' (1951) and Merry's (2002) understanding of an individual being the sole person to fully understand their perceived subjective world. Melanie, Kate and Ann's experiences expressed predetermined assumptions that didn't manifest as their reality (1.e.), and Melanie's experience of resentment of others mimic the "blurred boundaries between self and other" and the "challenges to women's self-understanding" denoted in feminist philosophers' workings (Mullin, 2005, p.91).

Ambivalence

It quickly became apparent from the findings that emotional ambivalence (2) was a prevalent experience for all four participants in accordance with Merriam Webster (2019) and Freidman's (2014) definitions of ambivalence and emotional ambivalence. It was evident that all four participants (Ann, *32-33*, Melanie, *104-105*, Louise *158*-159, 166 and Kate, *156-157*) had a felt sense of feeling opposite emotions at the same time describing an element of positivity

and in quick succession, a negative feeling or vice versa. Whilst expressing this sense of emotional ambivalence, it led three participants to describe a sense of tension or psychological conflict as mentioned by Friedman (2014) and Conner and Armitage (2008) making specific reference to expressing having 'very strange emotions' (Louise, *59*), feeling 'in a strange place' (Ann, *30-31*) and feeling the experience was 'very confusing' (Kate, *141-142*).

Both Ann (*30-31, 103*) and Kate (*13*) described ambivalence as a manifestation from body movements as Schneider (2013) had described, both referring to feeling 'torn' and 'in the middle'. Page's (1988) account of emerging feelings during pregnancy are echoed by the lived experiences of all four participants. Emotions and feelings including elation, scared, anxious, ecstatic, amazing, excitement, fear, positive, negative thoughts, happy, not happy and guilty (2) are all used to describe how the women felt about their pregnancy during the first trimester. Ambivalence is evident from these strong, contrasting emotions.

Sherr (1995) denotes that research is often biased on the presumption that pregnancy is deemed enjoyable. Geller (2014) also raises the awareness that pregnancy is assumptively associated with positive emotions and highlights that this is not the case for all women. Both Ann and Kate's accounts of their experience during the first trimester seem consistent with Sherr (1995) and Geller's (2014) observation of pregnancy assumptions due to circumstantial influences. Ann (*4-5*) spoke of her ambivalence (2) of feeling 'very happy about being pregnant, but not happy about the circumstances' referring to her relationship with her partner. Kate (*82-84*) spoke about feelings that emerged for her with reference to the timing of an unplanned pregnancy (1.b.,*151-152*) and starting a new job noting feeling 'ashamed' and 'very guilty at that time' but noticing that her and her partner were 'starting to get excited and happy'.

Koletzko et al.'s (2015) study highlights the missing field of examining ambivalence for wanted or planned pregnancies. Melanie (*10, 14-15, 43, 128-129, 187*) in 1.b. and (*91*) 1.a. recounted her emotions including depression, worry, anxiety and concern for her wanted and planned

pregnancies as a consequence of her previous experience of pregnancy loss. Although her spoken experience didn't directly assimilate emotional ambivalence, her intensified concern alongside her desire to be pregnant (1.a., 4) supports Koletzko et al.'s (2015) findings that depressive symptoms and perceived stress of experienced ambivalence can be associated with the decision to have a child. Louise also supports Koletzkos et al.'s (2015) findings and spoke candidly about embarking on a high-risk pregnancy due to age and medical circumstances. She relayed her initial feelings of 'elation' and 'excitement' were 'swallowed up' noting 'oh my gosh, this is real' with fears of what 'possibly could go wrong' (*158-159, 166*).

All four participants were consistent with Brown's (1998) notion, supported by Leiderman and Weis (2009)**,** that feelings of well-being prevailed simultaneous positive and negative experiences and tenderly spoke about their optimistic dominant emotional experiencing. Ann (*164-166*) expressed the 'overriding thing was that I was happy to be pregnant, to be having a baby… becoming a mum'**.** Louise (*167-168*) voiced 'the feeling of being happy never left'. Melanie (*11*) expressed 'I was a little bit anxious but really, really happy' and Kate (*68-69*) relayed when her and her partner got their 'heads around' the pregnancy, it 'felt… quite positive'.

Hearing participants' accounts of their emotional experiencing of the first trimester of pregnancy was key to this study as their narratives organically drew out and unfolded the magnitude of emotions and experiences the participants were dealing with during this time. The extent of these findings align with the workings of Maconochie et al. (2007), Qaio et al. (2009), Gourounti et al. (2013) and Rubertsson et al. (2014), all identifying that there is scope and further potential to look at factors that contribute to emotional dissonance during pregnancy with Rubertsson et al. (2013) making specific reference to looking at this during the first trimester. They also refer to suggesting further exploration looking into concepts to prevent or decrease the impact on both the mother and baby's wellbeing both perinatally and postnatally.

Perceptions of Support

Psychosocial support has been suggested to sport a positive influence on mental wellbeing and has been known to significantly enhance a women's emotional wellbeing during pregnancy (Wheatley, 1998). All four participants spoke about significant relationships (3.a.) including their partners, close friends and other family members who played a perceived positive and supportive role during the first trimester of pregnancy, echoing Lederman and Weis' notion that this small network provides "intimate care, protection and support nurturance" (Lederman & Weis, 2009, p.212). Louise and Kate spoke warmly about their perception of support from their partners (3.a.). Louise (*32-33, 371, 148a*) regarded the strength of her relationship with her current partner gave her a felt sense of emotional support and a sense of security within a shared responsibility. Kate (*170, 270*) relayed the significance of open communication and her husband being 'fantastic… at everything… from a support point of view'. Their perceptions of support bode well with Stapleton et al.'s (2012) findings that the impact of involvement and support can have on maternal health. Ann's (*23, 187-188*) relationship experience and Louise's (*77-78*) previous relationship experience relates to Bilszta et al.'s (2008) report that negative support experiences are more detrimental than having no partner at all. Louise (*219-220*) and Kate (*19-22, 76-77*) spoke about confiding in close friends to seek support and Ann (*133*) spoke about feeling understood when she confided in the fathers' mother. These perceptions compare to Carrick-Sen's (2012, p. 283) idea that some relationships are "reported to be more supportive than the woman's partner", certainly in Ann's experience and Louise's previous partner experience (Ann, *22*, Louise, *77-78*). However, Louise and Kate's (current partner) experience seemed to complement their perceived support from their partners rather than supersede it. All participants described perceptions of absent support (3.b.) that validate the significance of perceived support as mentioned in Weis (2006) and Gan et. al's (2019) studies. It also suggests that Wheatley's (1998) and Thomson and Schmied's (2017) recognition of the importance of psychosocial support is sound.

Perceptions of other aspects of support (1.e.) discussed by the participants included work, medical/health organisations including G.P, nurse and midwife correspondence and mental health services. The experiences of medical and health support and external agencies perceived by all four participants had an undertone of inadequacy resonating with the complaints noted by Sherr (1995) including poor levels of communication (Melanie, *12-14, 105-106*, Kate *350-351*) and disturbances in the continuity of care (Ann, *119-120*). Chalmers (2017) noted that some prenatal care was deemed to feel mechanistic or harsh. It is evident that Kate (*348*) and Melanie (*20-21*) perceived their experience as clinical and Ann spoke of her experience with the family support unit supporting her practically, yet not emotionally (Ann, *167-168*). Melanie (*51-53*) did however describe one nurse who adopted a more "psychologically supportive approach" during a particularly distressful time (Chalmers, 2017, p.25).

Missing Needs

There appeared to be an underlying tone from both literature and from all participants' perceptions that there seemed to be missing elements that would be useful to enhance a women's experience of pregnancy and more specifically for the participants in this study, for the first trimester of pregnancy. All participants' responses offer an account of what elements of psychosocial support are perceived to be missing from all sub themes under missing needs (4). These accounts coincide with Chalmers (2017) specific reference to women's preferences emphasising a more psychologically supportive approach to care. Sherr (1995) highlights the complaints surrounding clinical care including poor levels of communication, lack of continuity of care and depersonalization and Chalmers (2017) also refers to specific needs that warrant addressing, including offering continuity of a single care provider, providing education and decision-making involvement. These complaints and needs that warrant addressing during the antenatal period rang true across the findings looking at the first trimester of pregnancy.

Participants across the sample discussed their perceptions of emotional holding (4.a.) within their perception of psychosocial support. Kate (*205*) and Ann (*233*) directly felt that emotional support was the experience that they needed more of during their first trimester (4.a.). These experiences somehow feel contradictory from the derived message online from @allontheboard to seek support. Clearly these participants felt that there wasn't anyone or anywhere to help them seek support. In turn Jomeen and Martin (2014) highlight that screening for psychological distress was not observed in standard antenatal clinical practice and indeed is still not mentioned in the NICE guidelines (2019) for uncomplicated pregnancies. Melanie (*202-203*), Kate (*310-312*) and Ann (*238*) all suggest needing support for holding emotional distress during the first trimester for pregnancy loss, work-related stress and domestic abuse. The discrepancies between social encouragers suggesting women to reach out for support if needed and psychological distress not being screened for during the initial clinical practice for antenatal care bodes a clear gap that matches three of the participants' experiences of feeling there is no-one or no-where for them to gain emotional holding.

Wheatley (1998) and Thomson and Schmied (2017) both discuss the nature of psychosocial support offering a buffering or a barrier against stress. Melanie (*116*), Ann (*238*) and Kate (*310-312*) all share the sense that there was no-one to talk to about their emotional experiencing (1.a.) and in turn, Ann (*189-190*) and Melanie shared (*138-139*) that they felt there was nowhere during their first trimester.

Sherr's (1995) mention of poor levels of communication and Chalmers' (2017) mention of education resonated with Melanie, Kate and Louise's experiences of lack of clarity during their experiences (4.c.). Melanie (*211-213*) discussed that she didn't understand what was going on during the time of experiencing her pregnancy losses. Kate (*231*) described the feelings assimilating to a 'duck out of water'. Louise (*323-325*) stated that she had 'no kind of schedule' or 'any anticipation of how regularly midwife appointments' were expected. Kate felt expectations of antennal procedure 'should have been more explained' (*246-247*).

Louise and Melanie described their view surrounding their experiences of the lack of continuity in care (4.b.). Louise reverently disclosed that she felt that not having any one person to build a rapport with and the lack of consistency of a care team added to her anxiety. Melanie commandeered the idea of having a consistent one to one 'person' to build a relationship with. These desires correspond with Ball's (1994) suggestion that a professional helper can influence a situation deemed to be stressful.

The concept of depersonalization within, overtly described as a 'production line' like atmosphere by Sherr (1995) and also mentioned by Chalmers (2017) stating that delivering a simple routine and clinically focussed provision is not sufficient enough, resonated with Melanie (*188, 281*) describing her experience of clinical care (4.d.) during the time and the time leading up to her first antenatal scans as 'one rule for everyone' and 'sticking to the rule book'. She expressed that it 'would have been nicer to not have been treated so routinely'. Louise (*363-367*) also expressed the desire for more individually led support (4.d.) with similar reference to Chalmers' (2017) notion of 'education'. Louise voiced having access to information as and when she felt she wanted or needed it would have been useful. Melanie (*98-99*) felt that she wanted an early scan due to feeling nervous from her previous pregnancy experiences that didn't correlate with routine scans and also felt that a separate room would be more emotionally ethical to be able to go to rather than 'back in the waiting room, with all the babies and the mum's pregnant' (*228-230*).

Ann (*156-157*) felt that she wanted help, to make her feel safe during a time where she was experiencing domestic abuse whilst in her first trimester of pregnancy (1,d.). Although this need is not directly related to clinical care support, Chalmers (2017) mentions that women need not only psychological support, but also social and cultural support too.

Melanie (*202-203*) mentions a role of a counsellor to provide support to assist in 'getting her thoughts together'.

Summary

A considerable number of the findings have been supported by the literature explored; however subordinate theme 1.c. observed three participants sharing prominent feelings of isolation which didn't materialise from the literature review and therefore could subsequently be explored. From the missing needs expressed by the participants and the comparable literature, there may be scope to look at how the counselling profession could support or even fill the gap that is prominent for emotional psychosocial support.

Chapter 6: Conclusion

Reflections on Research

This small-scale research project achieved exploring women's emotional experiences during their first trimester of pregnancy through Interpretative Phenomenological Analysis (IPA). The participants' narratives were rigorously analysed and the findings from the analysis process yielded results that were predominantly consistent with relevant literature and research reviewed.

The participants in this study experienced a multitude of feelings and emotions during the first trimester of pregnancy including both positive and negative feelings. Experiences of emotional ambivalence were prevalent amongst the sample regardless of their previous circumstances from when they initially embarked on their pregnancy journey, supporting the findings of Cutler et al. (2017).

This study also explored women's perceptions of psychosocial support and it is clear from the findings that the reality and impact of perceived support during the participants' first trimester were deemed beneficial with reference to support from significant relationships reflecting the findings of Weis' (2006) study highlighting the importance of some form of perceived network of support as early as the first trimester (Lederman and Weis, 2009). The participants' perceptions specifically highlighted the significance of the partner's role which supported Stapleton et al's (2012) findings associated with improved maternal mental health.

The participants' perceptions of support did however highlight a considerable degree of missing needs with reference to emotional holding, continuity of support, clarity of the pregnancy process and individually-led support, particularly in the medical and health care domain, relaying Chalmers' statement that "women's preferences emphasised a more psychologically supportive approach" (Chalmers, 2017, p.25).

Further Research and Implications

This study has added to the conversation that there is scope for further research with the view to addressing women's mental and emotional wellbeing and the quality of support they receive during the first trimester of pregnancy. The findings and discussion of this study contribute to Rubertsson et al.'s (2014) view that factors contributing to the presence of anxiety during the first trimester of pregnancy need further investigation. This also adds to Cutler et al's (2017) exploration of how ambivalence manifests in women's lives after confirmation of pregnancy.

With the current initiative from the NSPCC (2019), "Fight for a Fair Start" campaigning for perinatal mental health support for every Mum; and from the missing needs voiced by the participants, there may be scope to look at how the medical and/or counselling professions could support or even fill the gap of supporting women during their perinatal experience including the first trimester of pregnancy.

This study highlights that every women's experience and every women's pregnancy is unique. Gauging a clearer understanding of women's experiences of their first trimester of pregnancy and beyond is essential for those in the medical and helping professions, including Person-Centred counselling. A counsellor can work closely with women, leaving aside their own frame of reference and adopt a women's frame of reference to sense the client's feelings or experiences of events in their world as if these were their own (Mearns and Thorne, 2013). Within the Person-Centred Counselling domain, women can be offered a sense of emotional holding.

Limitations

My research study has intended to have impact and importance. However, limitations of the IPA research method, determined that within this small-scale research study, only experiences of the four participants will be involved and may not fully relate to the wider community. The study's findings and discussion evolved from the IPA's 'double hermeneutic' process of

analysis, and therefore the data retrieved from the semi-structured interviews was limited to my individual interpretation (Smith, Flowers, and Larkin, 2009).

I am aware that concepts including participant circumstances, age, year of pregnancy and whether the experiences shared are from first or subsequent pregnancies may have influenced the research study; these limitations however are influential in the participants' phenomenological experiencing and so cannot be overlooked. Also, isolation manifested in both mine and three of the participants' experiences didn't materialise in the literature reviewed and therefore could subsequently be explored. Perhaps there would have been scope to look into this further if time and scale of the study were not restricted.

Personal Reflections

Completing this research has been an emotional yet refreshing journey for me. Many of the findings discussed resonated deeply with my own pregnancy experiences and has somewhat reassured and normalised my experiences of emotional ambivalence and perceptions of psychosocial support, giving me a sense of belonging. This study has also motivated me to contribute further in developing and improving inclusive access to perinatal mental health support.

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Appendices

Appendix 1: Literature Search Strategy

Proposed research title:

An exploration of women's experiences of emotional ambivalence during their first trimester of pregnancy and their perceptions of psychosocial support during that time. Aim 1: To examine a women's emotional experience of ambivalence during their first trimester of pregnancy. Aim 2: To explore a women's perception of psychosocial support during the time of their first trimester of pregnancy.

Main keywords:

emotion	ambivalence	first trimester of pregnancy	psychosocial	Support

Alternative search terms:

feeling	conflict	early pregnancy	emotional	Help
reaction	contradiction	prenatal	Psychological	Aid
emotional state	confusion	pregnancy	Social	Assistance
experience	uncertainty	antenatal	Community	Succour
	equivocal		Collective	
	anxiety		Societal	

Truncations and wildcards:

emot*	anxi*	preg*	soci*	suppor*
react*	uncert*	prenat*	psycho*	help?
experi*	ambiv*	baby?		
mental health		pregnant state?		

Boolean operators:

AND
OR

Some key phrase searches:

Emotional ambivalence AND pregnancy
Ambivalence AND first trimester of pregnancy
Pregnancy AND anxiety
Early pregnancy AND emotional ambivalence
First trimester experience OR early pregnancy
Pregnancy experience AND psychosocial
Support AND pregnancy
Mental health and first trimester of pregnancy
Preg* AND ambivalence
Emotional amb* AND antenatal

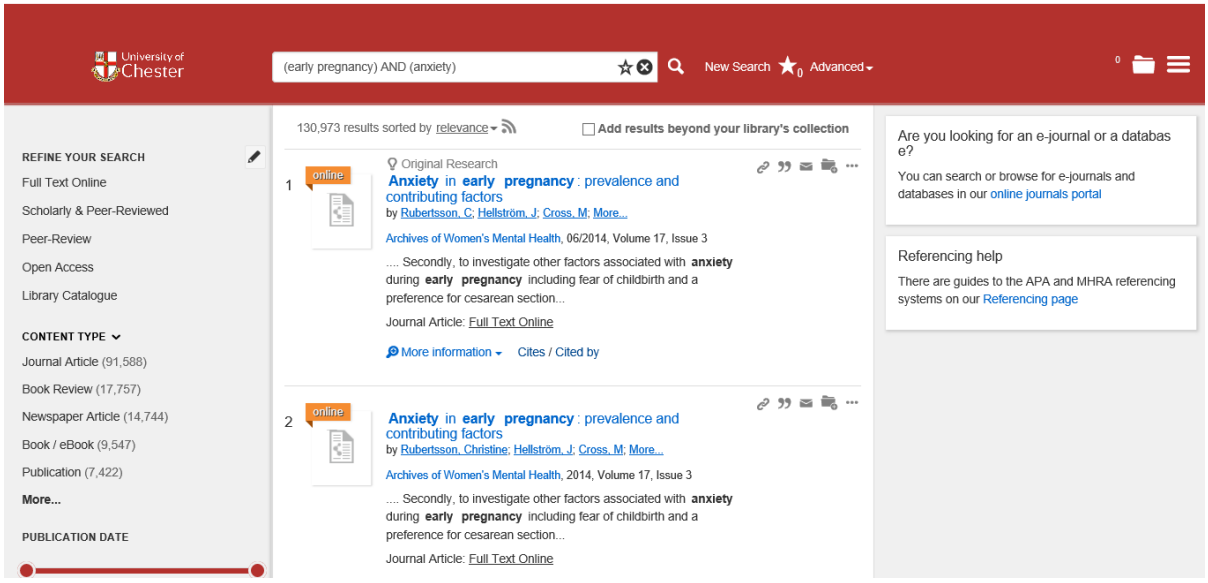
Resource databases to search:

Chester library catalogue
Online journals portal
Psycinfo
British Library's catalogue
Google
Wikipedia
Facebook

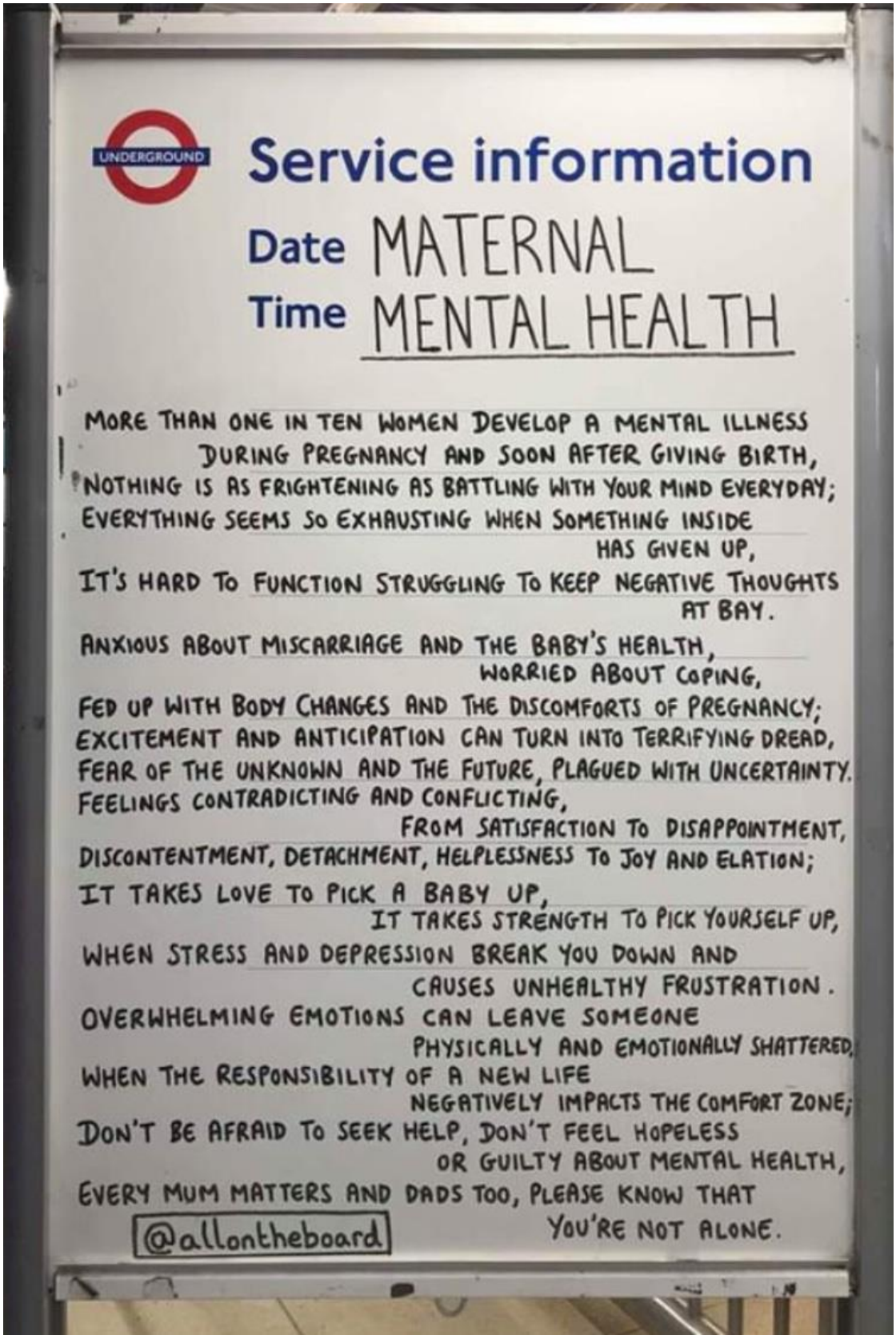
Appendix 2: Literature Search Screenshot

Screen shot of results from an initial literature search using keywords

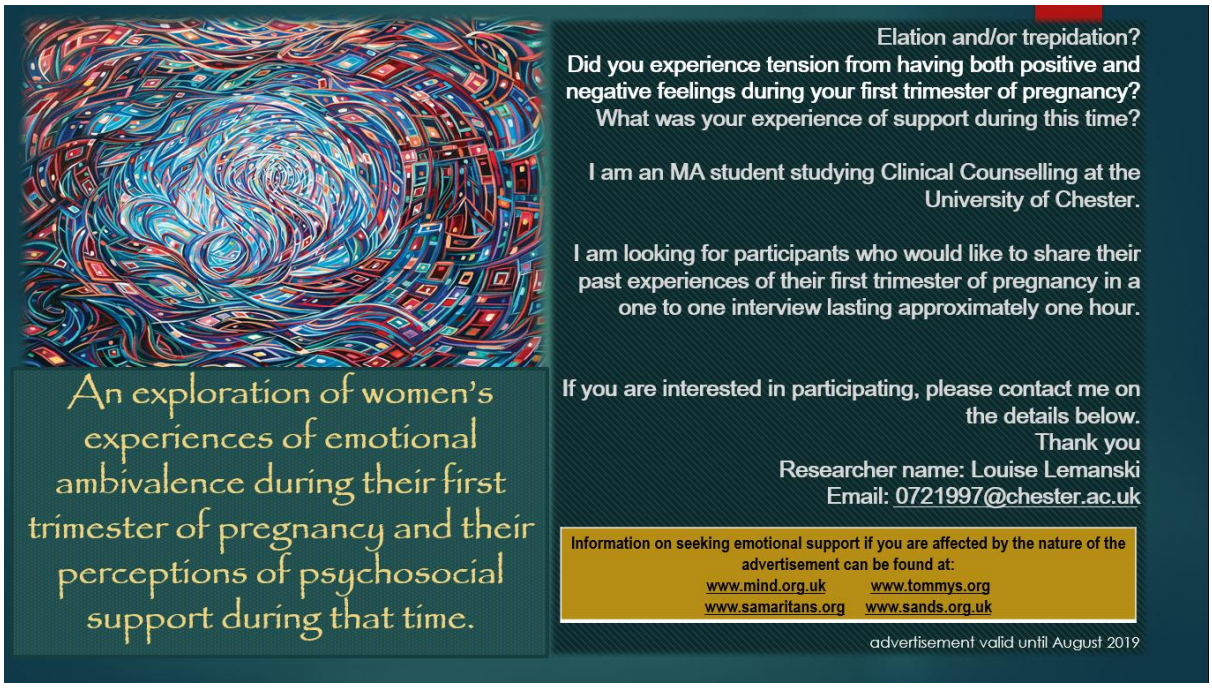
The first study listed lead to securing the drive to research experiences of the first trimester of pregnancy and opportunistically led to further literature sources.



Appendix 3: Facebook Post from @allontheboard



Appendix 4: Research Advertisement Poster



Appendix 5: Introductory Letter

Louise Lemanski
University of Chester
Parkgate Road
Chester
CH1 4BJ

Dear

Thank you for contacting me to express your interest in participating in a research study exploring women's experiences of emotional ambivalence during their first trimester of pregnancy and their perceptions of psychosocial support during that time.

Please find attached two documents:

- Research Information Sheet - providing further information about the study
- Research Study Inclusion Questionnaire – required to be completed to ensure eligibility

Please send your completed inclusion questionnaire to my email address: 0721997@chester.ac.uk. Please do not hesitate to contact me should you require any further information.

I look forward to hearing from you.

Yours faithfully

Louise Lemanski

Appendix 6: Research Information Sheet

Research Information Sheet

Title of the Research

An exploration of women's experiences of emotional ambivalence during their first trimester of pregnancy and their perceptions of psychosocial support during that time.

Dear

Thank you for indicating that you are interested in taking part in the research. This research information sheet will hopefully explain what is involved. If you need any clarification or further information, then please feel free to contact my using the contact details below.

Who am I?

I am an MA student at the University of Chester, studying for an MA in Clinical Counselling. As part of the postgraduate degree, I am required to produce a dissertation that involves a piece of research. I currently have counselling placements within a bereavement service centre and a women's centre offering person centred counselling to people experiencing difficulties with loss and grief and for women who are seeking support in making positive lifestyle choices and changes.

What is the study about?

My interest lies with exploring the juxtaposition a woman can emotionally find herself in combined with exploring the perceptions of support from psychosocial groups in order to gain a greater understanding based on lived experiences of the first trimester of pregnancy. This research study intends to explore experiences of emotional ambivalence a woman may have encountered during her first trimester of pregnancy. It also intends to explore the perceptions of psychosocial support and highlight the need or potential value support can have during this time to other women, social support networks and healthcare professionals.

Who will be asked to participate?

This study is looking for participants who:

- Are female
- Are 18 years old
- Have experienced pregnancy
- Have experienced a degree of emotional ambivalence during their first trimester and can identify perceptions of psychosocial support during that time

- Should feel sufficiently grounded to talk safely about their experience and should have an awareness of signposted support networks to contact if they feel they need to from the research information provided.

What does it involve?

Participation will include:

- Filling out a short study inclusion questionnaire.
- An optional preview of a copy of the questions going to presented during an interview.
- Signing a consent form agreeing to take part in the research study.
- 1 to 1 interview lasting approximately one hour. This can be conducted at a suitable and convenient location. (Refreshments i.e. tea, coffee, are available, up to the value of £5).

This will be digitally recorded, immediately transferred my private university One Drive for safe storage and transcribed. The transcriptions will be made anonymous and any details that could be used to identify you will be removed or substituted with pseudonyms.

- An invitation to view a written transcription of the interview.

This is to ascertain that it is a true reflection of your experience. You will have an opportunity to remove or amend any part of the transcription that you wish to. A transcript will be sent to your private email address which should be personal and secure and will be password protected. The transcription will be analysed using Interpretive Phenomenological Analysis. Your consent will be asked for any verbatim quotes, if needed, to appear in the research.

Data Protection

The audio recording of your interview will be stored on my personal university One Drive. The recording will then be transcribed and will be password protected and stored on my PC. Pseudonyms will be used in the transcripts to ensure anonymity. The interview audio recording and transcriptions data will be deleted from my university One Drive and my PC on on completion of my M.A qualification. Any electronic or hard copies of paperwork will be destroyed (shredded or electronically deleted) after 5 years in keeping with the data protection act other than the published research.

Can I withdraw?

You can withdraw from the study at any time without having to give an explanation or fear of reprisal, up until the point that the dissertation has begun to be written up. An email will be sent to you to advise you when I intend to begin the dissertation write up.

What are the Potential Risks?

There is potential that this study may raise sensitive issues for you surrounding the experience of pregnancy. I would advise you to have access to sufficient emotional support throughout the course of your time taking part in the research study and would be happy to provide you with details of registered counsellors in your locality. Please also refer back to the advertisement poster for information regarding organisations that may be of some use to access support.

What are the Potential Benefits?

This research study will present experiences of emotional ambivalence and psychosocial support that may have an impact on research readers to explore the gaps that may be highlighted in addressing further the first trimester of pregnancy experience and to look further into the perceptions of psychosocial support during this time. The study may highlight to counsellors and healthcare professionals that every women's experience of pregnancy is different and support and emotional holding of ambivalent feelings that could be explored within the counselling setting.

Ethics

The research project has been approved by the University of Chester's Ethics Committee. The research will be carried out in line with the BACP Code of Practice and Ethical Guidelines (2018) and the University's Research Governance Handbook (2018). I will be working under supervision from my university tutor who is also bound by these guidelines.

I am committed to everything within my ability to ensure your safety and confidentiality. However, if you are unhappy with any aspect of your involvement within the research study, I would ask you to firstly raise it with me. If you are still unhappy, you may contact my Research Supervisor, Dr. Rita Mintz at University of Chester: email: r.mintz@chester.ac.uk. If you are still unhappy, you may then contact the Social Science faculty at University of Chester: email: sps@chester.ac.uk. Please note that University of Chester Research Governance Handbook (2018) states that in the unlikely event "that a participant is harmed by taking part in the research, there are no special compensation arrangements".

How will the research be used?

The completed research will be stored (bound and electronic) at the University of Chester. Bound copies of the dissertation will be held after publication in the University of Chester's, Department of Social Studies and Political Sciences Counselling Resource Room. The completed research may be disseminated in future publications.

Can I see the completed research?

You will be able to see the completed research. I can be contacted via email and will arrange to have the research sent to your private email address which should be personal and secure. The completed research will be password protected.

Contact details:

Name of researcher: Louise Lemanski

Email: 0721997@chester.ac.uk

Thank you for reading this information sheet and for your interest in this research.

Appendix 7: Inclusion Questionnaire

Research Study Inclusion Questionnaire

I would be grateful if you could take a few moments to answer this short questionnaire in order for me to establish if the inclusion criteria for the study is being met.

Please circle the appropriate answer to the questions.

Questions	***Answers***	
Are you female?	Yes	No
Are you over the age of 18 years?	Yes	No
Are you fluent in the English Language?	Yes	No
Have you experienced pregnancy?	Yes	No
Are you currently pregnant?	Yes	No
Have you experienced a degree of emotional ambivalence during the time of your first trimester of pregnancy?	Yes	No
Can you identify your perceptions of psychosocial support during the time of your first trimester of pregnancy? *Please note - such support may or may not have been sufficiently present for you.*	Yes	No
Are you currently seeking counselling support for pregnancy related issues?	Yes	No
Do you feel sufficiently grounded to be able to talk safely about your experience?	Yes	No
Have you read the participant information sheet and are you aware of information given about accessing support if you wanted to?	Yes	No

Are you interested in taking part in the research and happy for me to contact you?	Yes	No

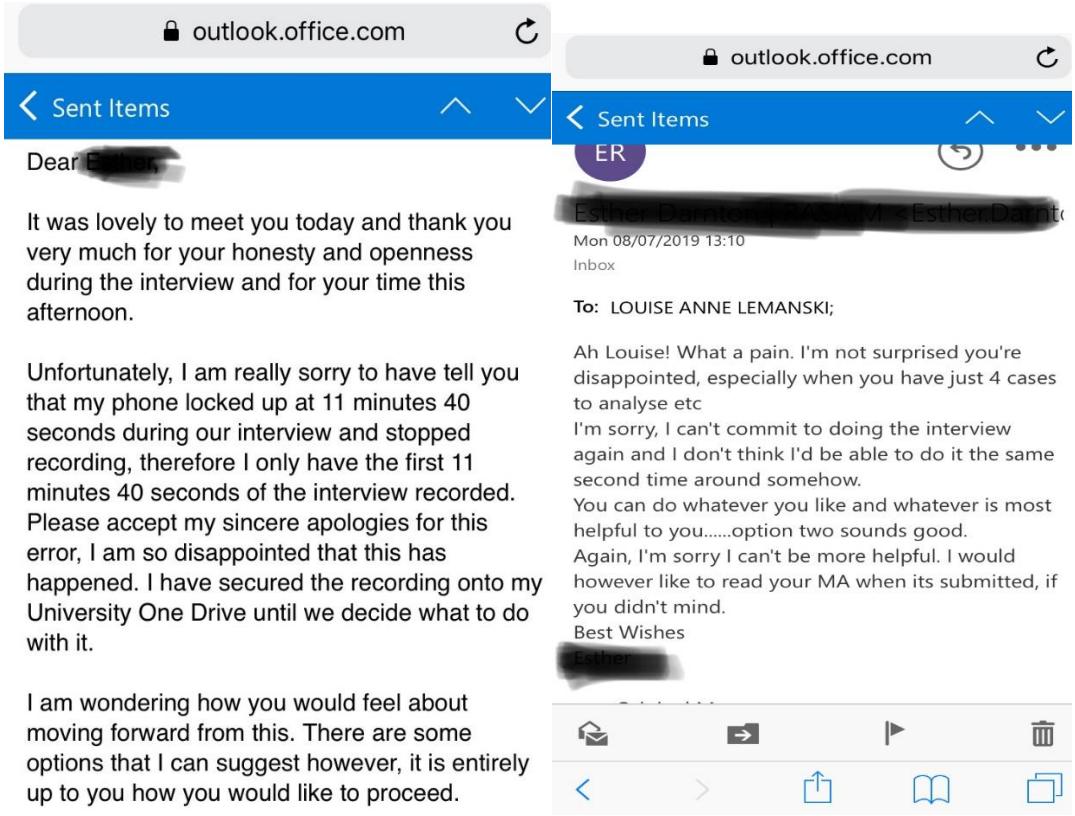
Name:…….

Contact Details:……

Thank you very much for taking the time to complete the questionnaire.
I will contact shortly.

Appendix 8: Pilot Interview Correspondence

Screenshot of pilot interview agreement



outlook.office.com

Sent Items

Dear [redacted],

It was lovely to meet you today and thank you very much for your honesty and openness during the interview and for your time this afternoon.

Unfortunately, I am really sorry to have tell you that my phone locked up at 11 minutes 40 seconds during our interview and stopped recording, therefore I only have the first 11 minutes 40 seconds of the interview recorded. Please accept my sincere apologies for this error, I am so disappointed that this has happened. I have secured the recording onto my University One Drive until we decide what to do with it.

I am wondering how you would feel about moving forward from this. There are some options that I can suggest however, it is entirely up to you how you would like to proceed.

- We could conduct the interview again at a convenient time and place for you.
- I could use our experience today as a pilot interview for my research and note our experience together and I can delete the interview recording.
- You could withdraw from the research study and I can delete the interview recording.

I really appreciate that this is not an ideal situation at all and again, offer my sincere apologies for this error. I would really be grateful if you could get in touch when you are ready to discuss what to do next.

Yours sincerely and best wishes,

outlook.office.com

Sent Items

ER

[redacted]

Mon 08/07/2019 13:10

Inbox

To: LOUISE ANNE LEMANSKI;

Ah Louise! What a pain. I'm not surprised you're disappointed, especially when you have just 4 cases to analyse etc

I'm sorry, I can't commit to doing the interview again and I don't think I'd be able to do it the same second time around somehow.

You can do whatever you like and whatever is most helpful to you.....option two sounds good.

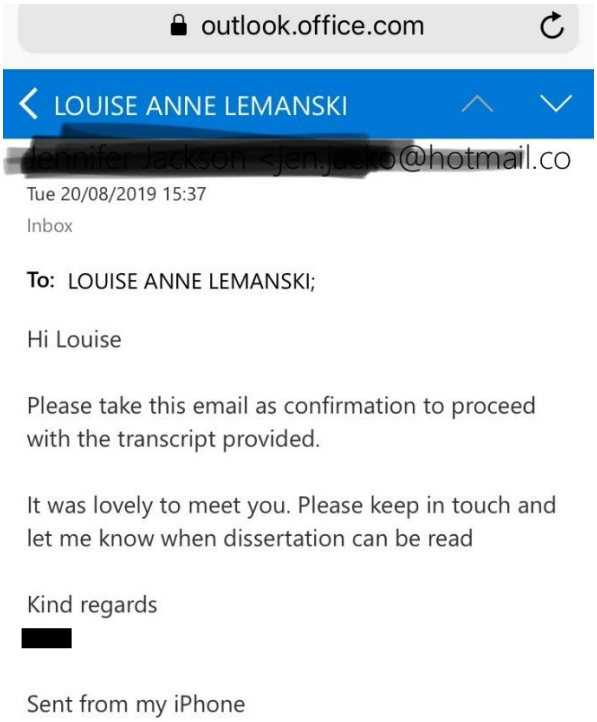
Again, I'm sorry I can't be more helpful. I would however like to read your MA when its submitted, if you didn't mind.

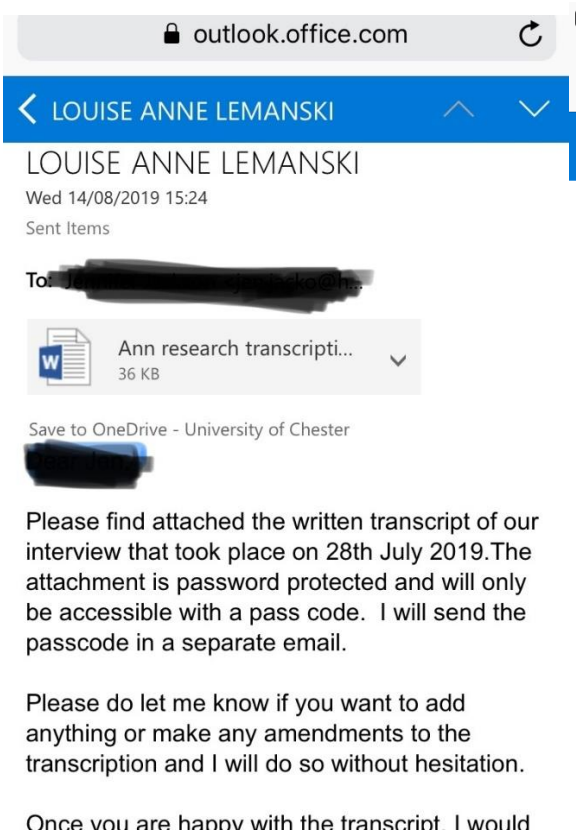
Best Wishes

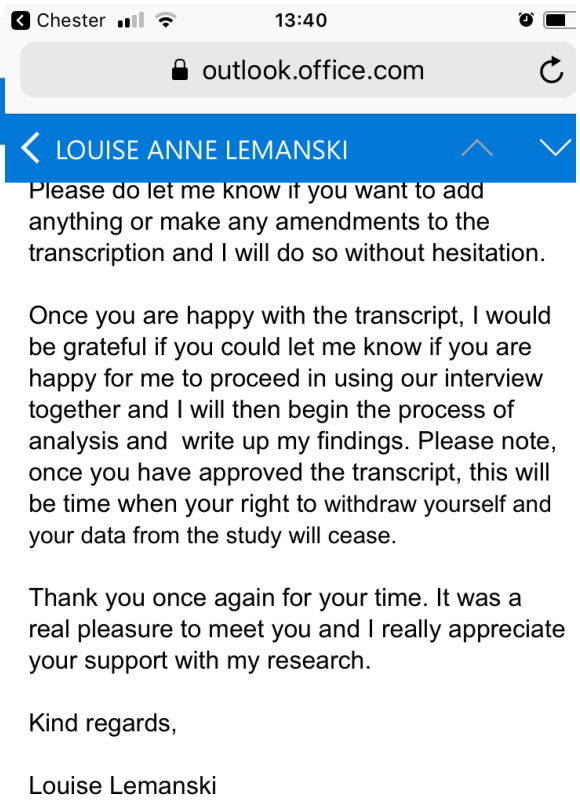
[redacted]

Appendix 9: Transcription and Withdrawal from Study Correspondence

Screenshot of transcription agreement and right to withdraw from study confirmation

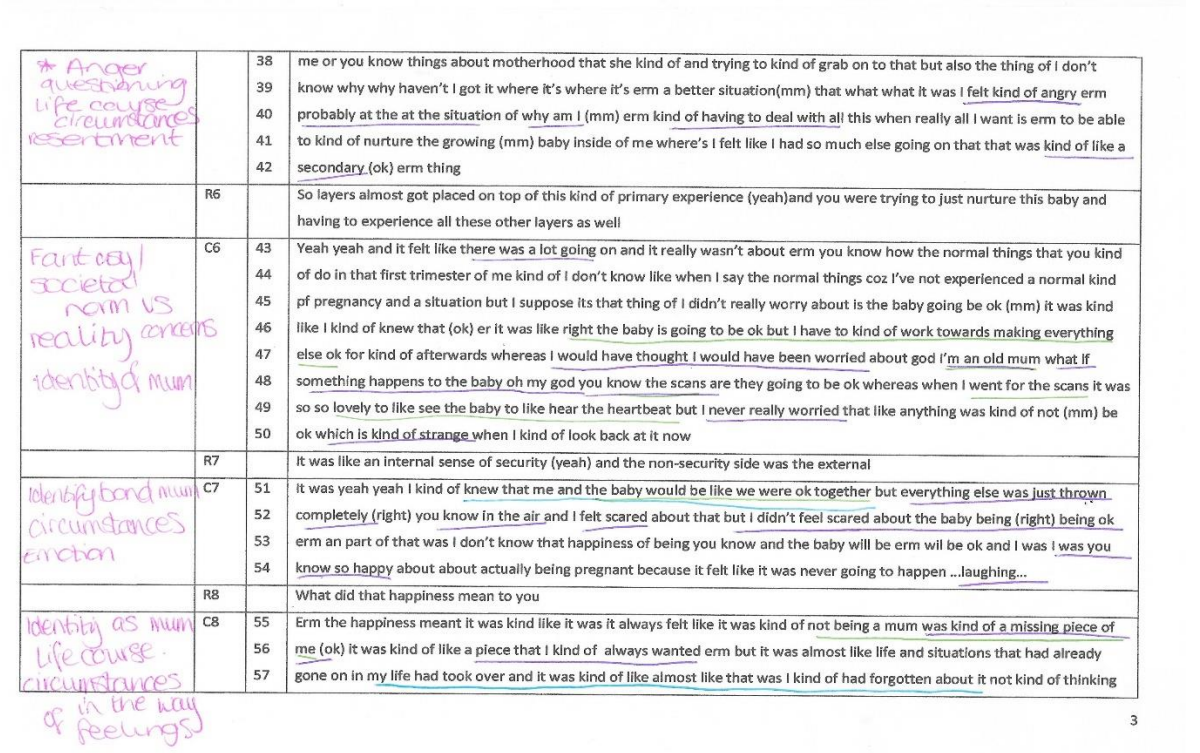






Appendix 10: Initial Noting

Step 2 - Data Analysis



* Anger questioning life course circumstances resentment		38	me or you know things about motherhood that she kind of and trying to kind of grab on to that but also the thing of I don't
		39	know why why haven't I got it where it's where it's erm a better situation(mm) that what what it was I felt kind of angry erm
		40	probably at the at the situation of why am I (mm) erm kind of having to deal with all this when really all I want is erm to be able
		41	to kind of nurture the growing (mm) baby inside of me where's I felt like I had so much else going on that that was kind of like a
		42	secondary (ok) erm thing
	R6		So layers almost got placed on top of this kind of primary experience (yeah)and you were trying to just nurture this baby and having to experience all these other layers as well
Fantasy/ societal norm VS reality concerns identity of mum	C6	43	Yeah yeah and it felt like there was a lot going on and it really wasn't about erm you know how the normal things that you kind
		44	of do in that first trimester of me kind of I don't know like when I say the normal things coz I've not experienced a normal kind
		45	pf pregnancy and a situation but I suppose its that thing of I didn't really worry about is the baby going be ok (mm) it was kind
		46	like I kind of knew that (ok) er it was like right the baby is going to be ok but I have to kind of work towards making everything
		47	else ok for kind of afterwards whereas I would have thought I would have been worried about god I'm an old mum what if
		48	something happens to the baby oh my god you know the scans are they going to be ok whereas when I went for the scans it was
		49	so so lovely to like see the baby to like hear the heartbeat but I never really worried that like anything was kind of not (mm) be
		50	ok which is kind of strange when I kind of look back at it now
	R7		It was like an internal sense of security (yeah) and the non-security side was the external
Identify bond mum circumstances emotion	C7	51	It was yeah yeah I kind of knew that me and the baby would be like we were ok together but everything else was just thrown
		52	completely (right) you know in the air and I felt scared about that but I didn't feel scared about the baby being (right) being ok
		53	erm an part of that was I don't know that happiness of being you know and the baby will be erm wil be ok and I was I was you
		54	know so happy about about actually being pregnant because it felt like it was never going to happen ...laughing...
	R8		What did that happiness mean to you
Identity as mum Life course circumstances in the way of feelings	C8	55	Erm the happiness meant it was kind like it was it always felt like it was kind of not being a mum was kind of a missing piece of
		56	me (ok) it was kind of like a piece that I kind of always wanted erm but it was almost like life and situations that had already
		57	gone on in my life had took over and it was kind of like almost like that was I kind of had forgotten about it not kind of thinking

3

C5 Anger led to questioning → resentment again?
Why!! External problems masked over nurturing baby/pregnancy experience

C6 A lot going on – overwhelmed
different feel experience correlated with 'normal'
Strong sense of baby is ok
questioning priority of worries ... I would have thought..
felt strange that they weren't concerns at the time ... although
so many other things happening at the same time.

C7 bond of baby and self
circumstances – made to feel scared
completely up in the air vs. so happy. actually being pregnant.

C8 missing piece of me → always wanted to be pregnant actualisation
life taken over so ~~better~~ forgotten about pregnancy desire.

3

Appendix 11: Emergent Themes

Step 4 - Analysis: Example of emergent theme table

Themes	Interview
Emotional experience	when I did find out I was pregnant I was made up (Melanie, 4)
	that's all I ever want (Melanie, 4)
Fantasy expectation	I just thought you get pregnant and that's it you tell everyone, nothing goes wrong it's just dead smooth (Melanie, 6-7)
Emotional experience	I was more nervous because of Oscar (Melanie, 9)
	I was really nervous (Melanie, 10)
Ambivalence	so I was a little bit anxious err but really really happy (Melanie, 11)
Support experience	basically questioned me on why do I think I'm pregnant (Melanie, 12-13)
	just asking loads of stupid questions (Melanie, 13-14)
Emotional experience	I was just really really concerned (Melanie, 14-15)
	that was devastating (Melanie,17)
	the worst thing was going out of that room and seeing all the other pregnant women around you (Melanie, 17-18)
Support perception	they don't feel remorse (Melanie, 18)
	they are not sorry (Melanie, 19)
	it was very clinical and nothing no support (Melanie, 20-21)
	There was no support we were basically handed over a tissue and that was about that the most support that you got (Melanie, 22)
Emotional experience – grief/ denial	just hope that there was a baby somewhere hiding (Melanie, 24)
Resentment	sitting there with young girls who want abortions so they are all like happy (Melanie, 25-26)
Pregnancy experience – loss/ grief	sitting there sobbing your heart about because you are about to say goodbye to this life that you thought you are going to bring into the world (Melanie, 26-27)
Support perception	there is absolutely no support (Melanie, 28)
Emotional experience	it was just really really hard for me (Melanie, 28)
Support experience	there is no support there is no advice nothing just a piece of paper saying this is what is going to happen you (Melanie, 33-34)

Isolation	dealt with it on my own (Melanie, 36)
Meaning making	only reason I managed to get myself out of the rutt is because I lost a friend through child birth and I tried to think well at least I'm still here (Melanie, 36-37)
Emotional experience	maybe God did the hard thing for me (Melanie, 38-39)4
Support experience	I was so anxious this time when I found out I was pregnant (Melanie, 43)
	I just had a meltdown but luckily, I had a nurse who was just hugging me (Melanie, 51)
Reassurance	she was the only one that I felt was supporting me everyone else it was just procedure (Melanie, 52)
Support perception	she was only one who actually gave me a hug and said everything will be ok (Melanie, 52-53)
	there is no one you can talk to they don't give you a counsellor to speak through what I went through (Melanie, 54-55)
Emotional experience	the nurses aren't very sympathetic it's just to them a foetus it's not a baby (Melanie, 55-56)
Support experience	I was very very nervous (Melanie, 180-181)
Emotional experience	and this nurse came to me and she was really nice and I told her what's happened previous and she said right I'll scan you now (Melanie, 82-83)
Support perception	my head well my world just came down, I just couldn't do it anymore I was just so low erm I was just really low and erm you know wasn't very good after that (Melanie, 84-85)
Emotional experience	I was like thank God for that (Melanie, 91)
	there is no emotional ask not counselling you know no emotional support at all (Melanie, 93-94)
Phenomenological experiencing	When you have lost two and you think now I've got to make a decision whether to lose this one as well and it is really really hard (Melanie, 94-95)
Support perception	that was a very on edge pregnancy all the way through because of all my experiences beforehand (Melanie, 96-97)
Support experience Emotional need not met– reassurance	there was nothing out there no one to talk to even like someone who has gone through the same (mm) to help you there's no like a group or anything (Melanie, 97-98)
Missing need	know I wanted to have an early scan because I was so nervous, they just wouldn't (ok) consider it (Melanie, 98-99)

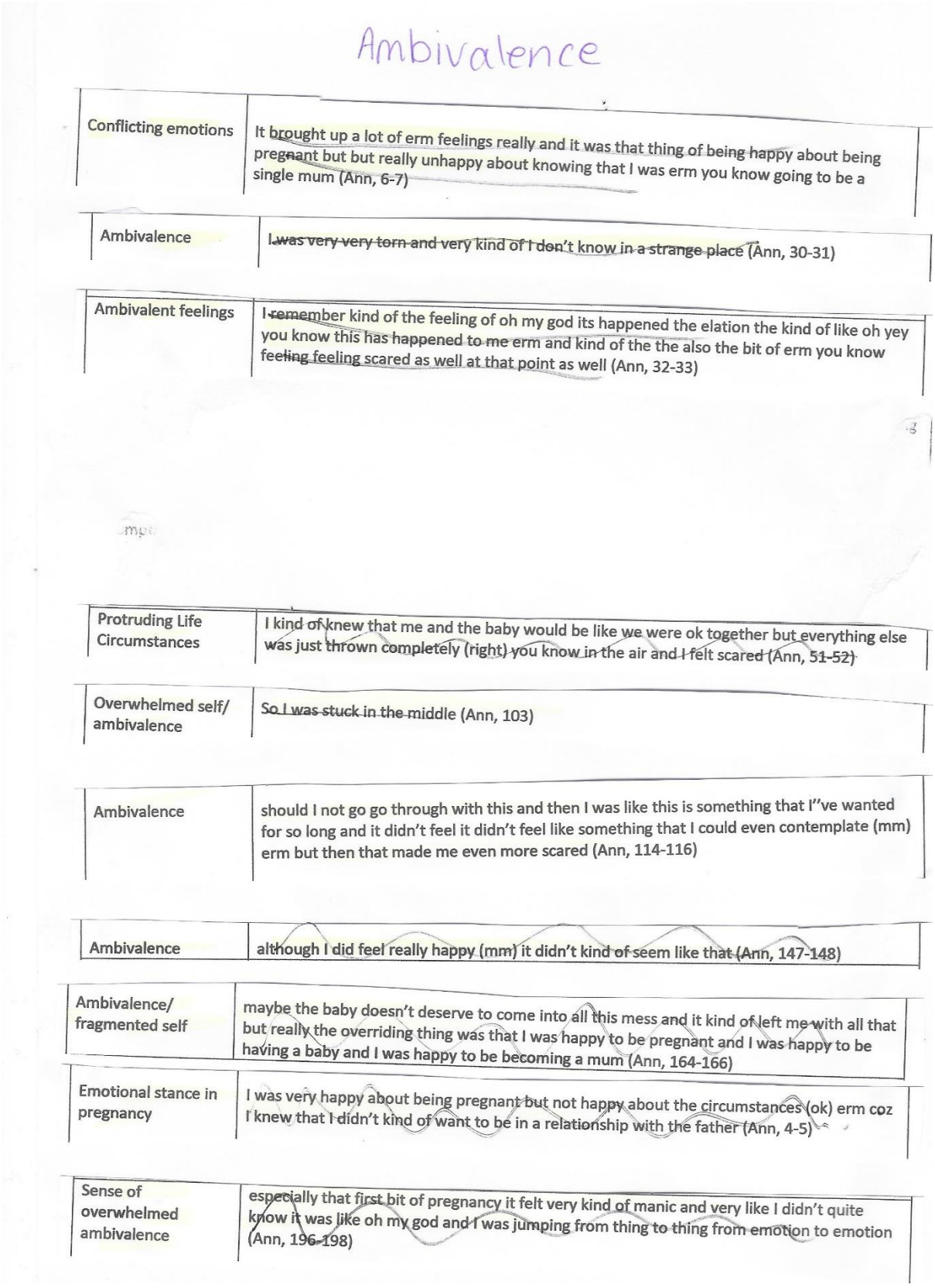
Emotional experience	
Ambivalence	I'm lucky to have my husband but he needed someone as well, like he was very upset I could see it erm yeah I needed more (Melanie, 100-101)
Self doubt – external experiences	I was made up it was my first pregnancy and you think everything's rosy and it just happens and that's the way it is (Melanie, 102-103)
Emotional experiencing - loss	I was a bit anxious when I found out I was actually pregnant I was ecstatic I was made up it was an amazing feeling (Melanie, 104-105)
Resentment	I felt like they thought I was lying about the whole experience that I had the way they were questioning me (Melanie, 105-106)
	I was just an emotional wreck (Melanie, 107)
Missing need	sobbing couldn't control my crying (Melanie, 107)
Emotional perception	and I felt angry as well seeing people outside the ward you know outside smoking pregnant and you know like drinking and I'm like
Support Perception	how are they having all these kids and I can't (Melanie, 109-110)
	a bit of jealousy you know when you get that jealousy bump envy and that's what I really wanted (Melanie, 111-112)
Emotional experience	I wanted to have… I wanted… I wanted to be pregnant (Melanie, 112-114)
Resentment	I was just it wasn't good after that yeah very angry with everyone (Melanie, 115)
Emotion -Isolation	there was no one to understand it it was yeah so I was on my own (Melanie, 115-116)
Support experience	no one to talk to (Melanie (116)
	I was quite negative about it I wasn't hopeful with it anyway (Melanie, 128-129)
	I was angry with him because I didn't want to know (ok) I wanted to carry on like I was pregnant and I just had to say goodbye to this one as well (Melanie, 133-134)
	not having a place to go not putting it to rest (Melanie, 138-139)
Choice of communication	I was basically fighting with my brain to not get in that black hole and you're fighting by yourself out of it (Melanie, 142-143)
	the cuddles in the evening and saying goodnight to him and that was the thing that helped me through it all (Melanie, 145)

Phenomenological experiencing	Oscar was my dream (Melanie, 151)
	I just stayed at home stayed in…didn't socialise just us three at home (Melanie, 156)
Support perception	My first pregnancy I did erm my first miscarriage I did that pregnancy I did tell everyone because I was so happy (Melanie, 162)
	the second miscarriage I told no one not even my mum (Melanie, 163)
Missing need	Luke knew about every single one like straight away (Melanie, 172)
Support perception Emotional experience	I don't think I told anyone as the time goes on you just get more just keep it to yourself because you experience it and you think there's a lot that go wrong and you don't want carry on telling everyone (Melanie, 169-171)
Support perception Missing need Support experience	even with your first pregnancy they don't explain things that's happening and you can't there is no where you think you can go and talk about your emotions or your anxieties about being a mum for the first time so when you have experienced losing then there is no I didn't feel like could go to the GP and say this has happened and you know there is nothing out there (ok) that I know of anyway
	I just wanted to have that reassurance of a scan (Melanie, 182)
Missing need Support experience	There was no support from there was no support experience from having miscarriages there was no support through this pregnancy to be positive (Melanie 187)
Missing need	I was very depressed with this one already I was very negative I was on anti-depressants from the beginning erm I was very low (Melanie, 187)
	the hospital was not understanding my background and was not willing to help (Melanie, 187)
	one rule for everyone kind of thing (Melanie, 188)
Phenomenological experiencing	we support each other the best we can but we don't always understand what each other is going through so I don't understand how he felt when we lost the first one and he didn't understand how I felt feeling (Melanie, 191-192)
Questioning self	they were sticking to the rule book (Melanie, 201)
	they weren't comforting nothing the weren't understanding (Melanie, 201-202)

Missing need	is having a separate area so for people who have had go for a scan and find out they've miscarried to go to a separate section instead of going back through were everyone is pregnant and all happy and looking scan pictures to go elsewhere to go to another room where you can sit down and get your thoughts together with maybe a counsellor or a nurse that can be a bit supportive and just talk to you for a minute (Melanie, 202-206) some kind of area to be able to speak and get your thoughts together because I didn't understand what was going on (Melanie, 121-213) everyone is different and everyone handles things differently (Melanie, 215) it would have just been nice to have been treated not so routinely (Melanie, 222) you do you feel guilty like what have I done wrong (Melanie, 231) you know why me (Melanie, 232) I think it would be good to have a one on one person that can build a relationship with you (Melanie, 249-250) To know you and understand your situation (Melanie, 250-251) I think you should have a one on one from the very beginning so that they can understand you as a person and how you are (Melanie, 255-256) some kind of support when they hear that they have miscarried instead of just left on their own to deal with it (Melanie, 271)

Appendix 12: Sub-ordinate Themes

Step 4 - Analysis: Clustered emergent themes to make a subordinate theme



Ambivalence

Conflicting emotions	It brought up a lot of erm feelings really and it was that thing of being happy about being pregnant but but really unhappy about knowing that I was erm you know going to be a single mum (Ann, 6-7)
Ambivalence	I was very very torn and very kind of I don't know in a strange place (Ann, 30-31)
Ambivalent feelings	I remember kind of the feeling of oh my god its happened the elation the kind of like oh yey you know this has happened to me erm and kind of the the also the bit of erm you know feeling feeling scared as well at that point as well (Ann, 32-33)
Protruding Life Circumstances	I kind of knew that me and the baby would be like we were ok together but everything else was just thrown completely (right) you know in the air and I felt scared (Ann, 51-52)
Overwhelmed self/ ambivalence	So I was stuck in the middle (Ann, 103)
Ambivalence	should I not go go through with this and then I was like this is something that I''ve wanted for so long and it didn't feel it didn't feel like something that I could even contemplate (mm) erm but then that made me even more scared (Ann, 114-116)
Ambivalence	although I did feel really happy (mm) it didn't kind of seem like that (Ann, 147-148)
Ambivalence/ fragmented self	maybe the baby doesn't deserve to come into all this mess and it kind of left me with all that but really the overriding thing was that I was happy to be pregnant and I was happy to be having a baby and I was happy to be becoming a mum (Ann, 164-166)
Emotional stance in pregnancy	I was very happy about being pregnant but not happy about the circumstances (ok) erm coz I knew that I didn't kind of want to be in a relationship with the father (Ann, 4-5)
Sense of overwhelmed ambivalence	especially that first bit of pregnancy it felt very kind of manic and very like I didn't quite know it was like oh my god and I was jumping from thing to thing from emotion to emotion (Ann, 196-198)

Appendix 13: Super-ordinate Themes and Identifying Patterns

Step 6 - Analysis: Highlighting patterns across all participants

Super-ordinate Themes and Themes – Melanie			
Emotional Experience	Ambivalence	Support experience	Additional needs
Fantasy expectation Positive experiences Negative experiences – feelings, grief/loss, resentment, isolation Lived experience Meaning making Pregnancy in relation to phenomenological experience	Conflicting emotions	Support network Positive support experiences Negative support experiences Support perception Partner relationship and connection External influences – questioning self Choice of support and reasons	Missing needs – resources/ information, reassurance, listening ear, environment

Super-ordinate Themes and Themes - Ann			
Emotional Experience	Ambivalence	Support experience	Additional needs
Overwhelming feelings Questioning the self and the life course experience Pregnancy in relation to phenomenological experience and self Isolation fantasy vs reality Identity as being pregnant/becoming a mother	Conflicting emotions Metaphorical representations	Support network Positive experiences Negative experiences External influences based on support experience Loss	Missing needs Need for reassurance

Super-ordinate Themes and Themes – Louise			
Emotional Experience	Ambivalence	Support experience	Additional needs
Positive experiences – feelings Negative experiences – anxieties, pressure, responsibility, risk Pregnancy in relation to phenomenological experience and self Self in life span – age as a positive, age as a barrier	Conflicting emotions	Support network Positive experiences Partner relationship and connection External influences based on feelings Choice of support and reasons	Missing needs – resources/ information

Super-ordinate Themes and Themes - Kate			
Emotional Experience	Ambivalence	Support experience	Additional needs
Fantasy vs reality Negative Emotional experiences – loneliness, upset, shame Positive emotional experiences Self worth Conditions of worth phenomenological experiencing self and motherhood self and age Reflection of experience External influences – finance, impact of work	Conflicting emotions Ambivalent experiences Ambivalent reflections	Support network Support experience Support perceptions Reflections of support	Missing needs Information Communication

Appendix 14: Consent Form

Consent Form

An exploration of women's experiences of emotional ambivalence during their first trimester of pregnancy and their perceptions of psychosocial support during that time.

Name of Researcher: Louise Lemanski Please initial box

1. I have read and understood the participant information sheet and have had the chance to ask questions. ☐
2. I agree to the research conversation being audio recorded. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time before the dissertation has begun to be written-up, without giving any reason. ☐
4. I agree to take part in this study. ☐
5. I understand that the data will be written up as part of a dissertation and I will not be identifiable in the dissertation. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature